Evaluation of Alcohol Referral Team and Drug Referral Team Services Final Report,

EVALUATION
OF ALCOHOL REFERRAL TEAM
AND DRUG REFERRAL TEAM SERVICES
FINAL REPORT

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Contents

Section		Page
1	**Executive Summary**	5
2	**Introduction**	11
3	**The Context for the Evaluation**	13
3.1	Scotland and the impact of drug and alcohol misuse	13
3.2	Drug & alcohol policy & research	14
3.3	Social Work policy & research	21
3.4	Conclusion	24
4	**Aims and Objectives**	25
4.1	Evaluating Outputs	25
4.2	Evaluating Effectiveness	25
5	**Research Methodology and Methods**	27
5.1	Methods	27
5.2	Sampling and recruitment	28
5.3	Data collection issues	30
5.4	Ethical issues	32
5.5	Analysis	33
5.6	Dissemination	34
6	**Findings: ART**	35
6.1	Evaluating outputs	35
6.1.1	*Services-level outputs*	35
6.1.2	*Service user-level outputs*	41
6.1.3	*Conclusion*	45
6.2	Evaluating effectiveness	46
6.2.1	*ART service user evaluations*	47
6.2.2	*Staff views*	48
6.2.3	*Referrers' views*	52
6.2.4	*Service users' views*	58
6.2.5	*Conclusion*	60
7	**Findings: DRT**	62
7.1	Evaluating outputs	62
7.1.1	*Services-level outputs*	62
7.1.2	*Service user-level outputs*	67
7.1.3	*Conclusion*	71
7.2	Evaluating effectiveness	71
7.2.1	*DRT service user evaluations*	72
7.2.2	*Staff views*	75
7.2.3	*Referrers' views*	82
7.2.4	*Service users' views*	85
7.2.5	*Conclusion*	87
8	**Final Conclusion & Recommendations**	88
8.1	ART findings	88
8.2	DRT findings	89
8.3	Common issues	90
8.4	Recommendations	93
9	**References**	94
10	**Appendix - Interview schedules**	99

Figures

Figure		Page
1	The Link between the Different levels of Outcomes (Scottish Government 2009c)	17
2	EADP Outcomes Menu	19
3	ART and DRT Outcome Measures	20
4	Gender and Age of Service User Informants	30
5	ART Outcome Measures	35
6	Referrals to ART in 2011	36
7	Reasons for Ending (ART)	37
8	Support Needed and Provided – 50 cases from 2011(ART)	39
9	Support Needed and Provided to those Fully Engaged (ART)	41
10	DRT Outcome Measures	63
11	Referrals to DRT in 2011	63
12	Reasons for Ending (DRT)	64
13	Support Needed and Provided – 50 cases from 2011(DRT)	65
14	Support Needed and Provided to those Fully Engaged (DRT)	67

1 Executive Summary

1.1 Introduction

This report outlines an evaluation of the Alcohol Referral Team (ART) and Drug Referral Team (DRT) within the Substance Misuse Sector Services of City of Edinburgh Council. The evaluation was commissioned by the Council's Department of Health and Social Care in February 2012 and conducted between February and July 2012 by a team of researchers from the School of Social and Political Science, The University of Edinburgh.

1.2 The context

Alcohol and drug misuse are key priorities for the Scottish Government. There has been a strong policy drive in this area, and a marked shift in direction from 'harm reduction' to 'recovery', with the added identification that substance misuse harms families and communities as well as individuals. The approach now being adopted by government largely draws on a social, not individual model, recognising also that recovery is a process not a single event. There has also, however, been a shift towards a more outcomes-driven approach, one that sets targets and gives value to the measurement of health outcomes at a range of levels. This has had an inevitable consequence on service-delivery agencies, which may experience tensions between externally-set targets and internally-negotiated goals of individual service users. Moreover, social workers now spend considerable time in completing the various tasks associated with outcome measurement. This is the context in which this evaluation, and the services themselves, are located.

1.3 Aims and objectives

The aim was to evaluate the City of Edinburgh Council's Alcohol Referral Team and Drug Referral Team's services. The evaluation had two broad objectives. It sought to evaluate:

- Outputs (an evaluation of process – what was achieved?) and
- Effectiveness (how well was it achieved?)

1.4 Methods

The evaluation used a mixed method approach, including both qualitative and quantitative methods, conducted between February and July 2012:

- A targeted literature review of relevant national and local policy documents and research evidence.
- Analysis of ART and DRT services' reports and case-records.
- Participant observation (shadowing social workers on visits to service users).
- Focus groups with social work staff from ART and DRT.
- Interviews with different stakeholders (the services manager, team leaders and a sample of referrers and service users for both ART and DRT).

Two key limitations emerged in the evaluation. The first relates to what we have identified as gaps in the case-records, affecting the comprehensiveness of the quantitative data collection. The second stems from the sample of informants; there may have been service users and referrers who would have liked to take part whom we were unable to reach in the evaluation. We have, nevertheless, elicited a diverse range of opinions in spite of this.

1.5 ART Findings

ART's stated outcome measures include: reduction in alcohol consumption; improvements in employment and accommodation status; improvements in financial situation; improvements in contact with non-alcohol users; and more and better use of a range of services.

Outputs

The findings suggest that ART service users are, on the whole, an older client group, predominantly white with a range of complex needs. Child protection does not feature highly, reflecting the age of service users. The evidence suggests that the agency addresses a range of issues and provides support in terms of referral, advocacy, emotional and social support and information and advice. Service users said they had been helped, in sometimes small, but realistic ways, and that help with welfare rights or housing in the first instance may be a necessary prerequisite for recovery later on. It is suggested that ART could do more to engage with young women and to address the needs of the BME community.

Effectiveness

The findings indicate overall that ART is providing a professional, expert and useful service to a range of troubled and troubling clients. There is consistent evidence of alcohol reduction amongst service users and improved feelings of well-being. The chaos of daily living is improved through access to ART services, but it is difficult to quantify this, not least because all service users are also in touch with other services (often as a direct result of ART

involvement). Service users acknowledged that ART social workers had played a key part in their recovery journey. This was largely down to the relationship that they were able to build with their social workers. It was also reflective of the professional identity of social workers, an identity that gave them expert knowledge and allowed them to leverage resources to assist clients to achieve their objectives. There was, however, concern stated by all those who took part in the evaluation that the rigidity of the 16-week programme may have impeded progress for some service users. The importance of good communication was stressed, between staff and service users but also between agencies and professionals.

1.6 DRT Findings

DRT's stated outcome measures include: reduced use of (illicit) drugs; improved psychological health, reduced chaos is daily living; increased self-worth; increased access to a wide range or treatment and other therapeutic interventions and children are safer.

Outputs

Findings suggest that service users are mainly under the age of 40 years; this is quite a different profile to the ART service users. A small number of service users had responsibility for the care of children, who either live with them or who are 'looked after' elsewhere. In common with ART, there were very few BME service users. A high percentage of service users had physical and mental health problems. A majority of referrals come from health sources. The evidence suggests (again as with ART) that the agency does address a range of issues and provides support in referral, advocacy, emotional and social support and information and advice. A high number of needs were addressed by those who completed the programme, focusing on housing, finance and social support, including education. The lack of services to which DRT social workers could refer those with mental health problems was highlighted in the evaluation.

Effectiveness

A number of conclusions emerge. Service user evaluations highlight the range of help people receive. Clients reported being better off after intervention: about half reported a decrease in their prescriptions, whilst a smaller number said they were using illicit drugs less often (some said they were no longer using illicit drugs). Most service users stated that their physical and mental health had improved, probably because other aspects of their lives were improved (such as housing, finance and social support). However, the interviews also highlight the challenging landscape in which DRT operates. Referrers and service users saw

the service in positive terms and all three sets of interviews assert that DRT's effectiveness is linked to positive relationships that social workers are able to develop with clients. Referrers were positive about the role of DRT in relation to child protection and appreciated their specialist knowledge and skills in this area. Those service users from within our sample who had contact with children felt that their relationship with their children and families' social worker had improved, as had contact with their children, suggesting an important advocacy role for DRT.

1.7 Common issues between ART and DRT

There are a number of systemic and organisational components common to both ART and DRT that frame the service delivery, bringing opportunities and challenges for consideration.

Nature of service delivery

Both ART and DRT are, as their name suggests, referral agencies: their task is to carry out a full assessment and then refer people on to other agencies and services. They are not, in this sense, therapeutic agencies, but they are, nevertheless, 'social work' agencies: intervention is carried out by qualified social workers who have all undergone further professional training in substance use. We were asked to consider: what is the 'added value' of a social work response like this to supporting people with alcohol and drug problems? It has proved impossible to answer this question categorically, not least because we did not set out to compare and contrast outcomes with those who did not receive a social work service. The closest answer we can give, however, picks up a number of points made by referrers and service users, that is, that ART and DRT provide a holistic service: a service which sees individuals within the full context of their individual histories, lives, families and communities, and seeks to walk alongside service users as they make changes towards recovery. It is this willingness to see beyond the identified problem and to build relationships that is the hallmark of a social work service.

Being a social work service run by the Council also brings 'added value' in terms of knowledge of, and access to, other services. Both referrers and service users said they appreciated that as social workers employed by the Council, ART and DRT staff had easy access to other council-run services, including, of course, social work services. They also had expert, 'insider' knowledge of social work and social work processes and referrers and service users were able to take advantage of this. This was particularly identified in the context of child protection, a field of practice with which other addictions' agencies clearly feel less comfortable.

Beyond this, ART and DRT provide a unique service, one which focuses on the needs and strengths of service users. The assessment and care plan that is developed follows the aspirations and goals of service users, not simply agency targets. A flexible approach means that service users can be visited at home, met in a café or accompanied on visits. Service users and referrers commented on this most positively, as well as on the emphasis on social activities and building structure in daily life. There were, however, quite divergent opinions about the services' 16-week programme, with some views expressed that this could never be enough to do anything other than start someone on a recovery journey. (While service users can and are re-referred at the end of 16 weeks, we heard that this may lead to a delay because the person is placed on the waiting list again.) Some informants felt that brief intervention like this is helpful, because it reduces the likelihood of dependency. Interestingly, in both ART and DRT, the focus of intervention is likely to be on an issue such as housing, finance or social aspects, rather than on either alcohol or drug issues directly. This is because in all instances, a health professional was also working with the client. There is some evidence from the evaluation that the amount of agencies and personnel involved in a service user's life can be confusing and there is an important role for ART and DRT in facilitating access between different professionals. The new 'recovery hubs' promise much for future inter-agency working, although significant differences of epistemology and approach in relation to drug and alcohol misuse are likely to remain (especially focused on the question of abstinence).

Nature of the service deliverers

The success or failure of a service like ART and DRT is largely down to the professionalism and experience of its staff. Because ART and DRT are referral agencies, they have nothing to offer but themselves; the relationship between the service user and social worker is at the heart of the case management approach adopted. The social worker acts as a catalyst to change, as long as the service user is ready and willing to commit to change. The social worker must also be able to address complex needs. At times, this means coping with difficult and challenging behaviour, and being able to 'hold' a person through their distress, even though this is not intended to be a therapeutic relationship. Achieving this balance requires good training and support, both of which have been identified by ART and DRT staff and referrers.

Nature of the systems and structures within which the agencies operate

A number of different sets of outcomes and targets have been identified by this evaluation, and ART and DRT have to demonstrate performance across all of them. There are, moreover, a number of different systems in place for recording, leading to inevitable repetition in some places, and gaps in others, and also great difficulty in identifying just what has happened with each service user. This has implications not only for agency monitoring processes, but also for work with service users, and for contact with other agencies, many of whom said they would like to hear how the client they had referred had fared.

There have been a number of suggestions in this evaluation that ART and DRT might come together in the future. Whilst this was not a topic that we set out to investigate, it should be stated that there are clearly pros and cons to this development as identified in the evaluation. Whatever happens, it is important that both services maintain close links in the future.

1.8 Recommendations

- That ART and DRT continue to provide services to these client-groups.
- That DRT continues to provide specialist child protection services to what is an exceptionally difficult service-user group to engage with.
- That ART and DRT reconsider the 16-week service time-limit to see whether a more flexible approach might yield improved outcomes for service users.
- That ART and DRT revisit their record-keeping systems in order to simplify systems and provide useful evaluative information.
- That ART and DRT standardise their systems across the agencies so that it is easier to draw comparisons between service user groups.
- That ART and DRT explore what needs to be done to make the services more accessible to black and minority ethnic people in the future.
- That ART and DRT improve their feedback of service users' progress to referrers.
- That ART and DRT explore ways of involving service users more in service development.

2 Introduction

This is an evaluation of the Alcohol Referral Team (ART) and Drug Referral Team (DRT) within the Substance Misuse Sector Services of City of Edinburgh Council. It does not cover the Residential Rehabilitation Referral Team, also run by the City Council. The evaluation was commissioned by the Council's Department of Health and Social Care in February 2012 and conducted between February and July 2012 by a team of researchers from the School of Social and Political Science, The University of Edinburgh.

Before beginning the evaluation, the research team met the ART and DRT manager and team leaders to discuss the approach that would be adopted in the evaluation. ART and DRT social workers and administrators gave day-to-day support during the evaluation, including facilitating access to agency records, referrers and service users. The research team met ART and DRT staff following submission of the evaluation report to discuss its findings. The summary of key findings was sent to all those who took part in the evaluation.

The report begins with a discussion of the context for the evaluation, in terms of both policy and practice as they relate to social work and to addictions' services. Key research studies in relation to drug and alcohol use are introduced, before a summary of key findings is presented. The main body of the report outlines the aims and objectives, research methods, findings and conclusions of the evaluation. The appendix includes an interview schedule.

Abbreviations

The following abbreviations are used at various points in the report:

AA	Alcoholics Anonymous
APS	Alcohol Problem Service
BME	Black and Minority Ethnic
CDPS	Community Drug Problem Service
CPN	Community Psychiatric Nurse
CREW	Crew 2000 (a drugs support service)
EADP	Edinburgh Alcohol and Drug Partnership
EDAP	Edinburgh Drug and Alcohol Partnership (as above – both terms are used)
ELCA	Edinburgh & Lothian Council on Alcohol
EMEDI	Edinburgh Minority Ethnic Drugs Initiative
GP	General Practitioner (doctor)
LEAP	Lothian and Edinburgh Abstinence Programme
NEDAC	North Edinburgh Drug and Alcohol Centre
MELD	Mid and East Lothian Drugs
OT	Occupational Therapist
Ritson Clinic	Detox Ward, Royal Edinburgh Hospital
SACRO	Safeguarding Communities Reducing Offending
SWIFT	Social Work Systems Modernisation Project

3 The Context for the Evaluation

This evaluation must be located in Scotland's current economic and social climate, and in drug and alcohol and social work, policy, practice and research.

3.1 Scotland and the impact of drug and alcohol misuse

People in Scotland have faced challenging economic and social times in recent years, with increasing unemployment, diminishing affordable housing options, changes in welfare benefits and a growth in poverty (Parekh et al., 2010). More challenges lie ahead with the anticipated Welfare Reforms Act. These changes threaten to increase the growing gap between rich and poor, leading to social polarisation (Wilkinson and Pickett, 2009). For some families this has meant, 'four generations of deprivation, worklessness and declining life expectancy' (Scottish Executive, 2006a). People of low socio-economic status are often located in identifiable communities where there is a high prevalence of drug and alcohol misuse, offending behaviour, low educational attainment and poor health. Social work faces growing pressures in 21st Century Scotland:

> 'Society will need to find long term and more effective ways to change these communities if an inexorable rise in social problems and the caseload of social work services is to be halted. Social work will have a significant role in this, promoting community responsibility, resilience and capacity and linking people to resources within their community' (Scottish Executive, 2006a: 20).

Drug and alcohol misuse are central to Scotland's social problems. It is generally accepted that Scotland has higher rates of drug and alcohol problems than other parts of the UK and many other countries in Europe (Audit Scotland, 2009; UNODC, 2010; Scottish Government, 2010a and 2011). Drug and alcohol misuse impacts on society in terms of healthcare, social care, crime, economic productivity and the human cost of suffering caused by premature deaths. There are approximately 59,600 individuals with problem drug use in Scotland (Scottish Government, 2011). This has an estimated economic and social cost of £2.6 billion per annum and there are around 485 drug-related deaths per annum (Scottish Government, 2008; General Register Office for Scotland, 2011). Alcohol misuse has a significantly higher impact on Scottish society if measured by economic impact, costing the economy an estimated £3.56 billion per year (Scottish Government, 2010a). Drug and alcohol misuse have serious negative consequences for all those involved, adults and young people, family members and children alike, as well as for society as a whole. There are strong links

between social inequalities and drug and alcohol misuse (Scottish Drugs Forum et al., 2008; Shaw et al., 2007). Those with drug problems have an estimated unemployment rate of 85% and 80 to 90% of Scottish prisoners have been misusing drugs and alcohol (Shaw et al., 2007: 6).

3.2 Drug and Alcohol Policy and Research

The Scottish Government has taken the lead in identifying the need to confront drug and alcohol abuse as a priority for policy and practice (Scottish Executive, 2001; Scottish Government 2008a, 2008b & 2008c; Scottish Government, 2009a). Moving away from a 'harm-reduction' focused policy, it has identified a 'recovery-oriented' approach as the 'new way forward' in tackling drug and substance misuse problems, with recovery described in its recent strategy report, *Road to Recovery* as:

> 'a process through which an individual is enabled to move on from their problem drug use, towards a drug-free life as an active and contributing member of society… recovery is most effective when service user needs and aspirations are placed at the centre of their care and treatment. In short, an inspirational, person centred approach' (Scottish Government, 2008c: 23).

The *Road to Recovery* proposes that all forms of treatment should promote recovery, although it is acknowledged that recovery journeys may have different routes for different individuals. This may mean stabilisation, improvement of health, reduced drug use or abstinence (ibid.: 26). The report further states that there is a need for more integration between services with different emphasis, such as 'mental health, homelessness and employment' (ibid.: 27). There is a strong emphasis on protecting children, supporting the families of problematic drug users and involving family members in the process of treatment, care and support (Scottish Government, 2008c: 7, 24, 31).

The Scottish Government's *Changing Scotland's Relationship with Alcohol: A Framework for Action* (Scottish Government 2009a) similarly asserts that there needs to be a 'culture change' if Scotland's relationship with alcohol is to be improved. The report states that the harm caused by alcohol misuse has become a major challenge affecting Scottish society and action needs to be taken 'through legislative change and improved services and treatment, and by building an environment that supports cultural change in the longer term.' The report calls for sustained action in four areas: reduced alcohol consumption; supporting families and communities; positive public attitudes, positive choices; and improved treatment and support.

Both these policy initiatives have been taken forward through the Drugs Strategy Delivery Commission, the Scottish Drugs Recovery Consortium and through local Alcohol and Drug partnerships (ADPs). The Edinburgh Alcohol and Drug Partnership (EADP/EDAP) was formed in November 2009 as the forum to take forward local planning around alcohol and drug issues. It consists of a range of organisations and stakeholders whose aim is 'to work together to support individuals and their families into their recovery and to make communities that are affected by alcohol and drug use stronger and safer' and to 'implement the national drug and alcohol strategies at a local level' (EADP, 2011b: 1, 4).

Underpinning the policy initiatives is, of course, an idea of what 'recovery' means. EADP adopts the US Centre for Substance Abuse Treatment's (CSAT) (2009) series of principles to define recovery. This states that:

> 'There are many pathways to recovery. Recovery is self-directing and empowering; recovery involves a personal recognition of the need for change and transformation; recovery is holistic; recovery has cultural dimensions; recovery exists on a continuum of improved health and wellbeing; recovery emerges from a process of healing and self-redefinition; recovery involves addressing discrimination and transcending shame and stigma; recovery is supported by peers and allies; recovery involves rejoining and rebuilding a life in the community. Recovery is a reality' (EADP, 2011b: 6)

The notion that drug and alcohol problems are social, not just individual, is picked up in an independent enquiry that criticises the *Road to Recovery* for not being sufficiently clear about what recovery means in practice and for not going far enough to address Scotland's problems (Matthews, 2010). The enquiry team asserts that the government's recovery policy will only have a real impact if bureaucracy is combined with 'less tangible but equally important influences that operate in the life of the drug user' (2010: 11). It argues further that alcohol and drug problems are 'fundamentally social'; that there needs to be a move away from 'medicalised and criminal justice approaches' towards a more holistic approach focusing 'on purpose and meaning, child and family welfare, employability, family support and community will' (2010: 13). The enquiry report calls for a new dynamic adopting a 'whole population approach' and 'a personalised approach to supporting those with 'overwhelming involvement' - 'the circle of care' (2010: 14).

This connects strongly with White's (2007) earlier definition of recovery:

> ‘Recovery is the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life’ (White, 2007: 236).

Best et al (2010) offer further insight. They reviewed all available evidence, pointing out that there is little UK-based research on recovery and the international evidence base is limited. In spite of this, they conclude from the existing research that:

- Sustained recovery is the norm, although the time to recover and the pathways involved are highly individualistic.
- The best predictor of the likelihood of sustained recovery is the extent of ‘recovery capital’ or the personal and psychological resources a person has, the social supports that are available to them and the basic foundations of life quality, i.e. a safe place to live, meaningful activities and a role in their community (however this is defined).
- Barriers to recovery include psychological problems (mental illnesses and the absence of strengths, such as self-esteem and self-efficacy), significant physical morbidities (including blood borne viruses), social isolation and on-going chaotic substance use.
- While structured treatment has a key role to play, it is only part of the support that most people will need. Ongoing support in the community is essential for the ongoing recovery journey and often includes mutual aid and other peer support.
- Recovery is not just about the individual, but impacts on families and communities.
- Switching to a recovery model requires a fundamental change in the culture and attitudes of professionals and communities (Best et al, 2010: 8).

Whilst recovery may now be the larger goal, Scottish Government has also given further guidance to ADPs about how this might be achieved in practice. The *Delivering Better Outcomes* ‘toolkit’ published in 2009 heralds the move to an ‘outcomes approach’, with national outcomes, targets, and indicators specified, as a means to ‘improving service delivery and recovery’ (Scottish Government, 2009c). The toolkit states that ADPs must seek to make connections between service delivery outcomes, intermediate outcomes, high level outcomes and national outcomes. A worked example is given below:

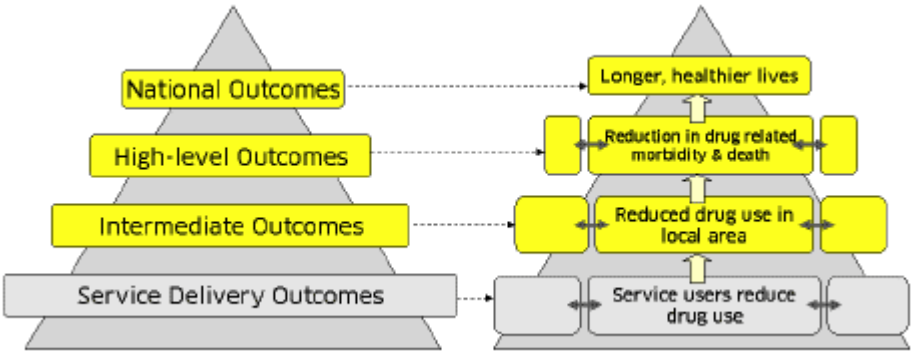

Figure 1: The Link between the Different Levels of Outcomes (Scottish Government, 2009c)

Although published in 2009, this report's findings were not fully implemented across EADP until 2011. In the intervening period, EADP had commissioned a needs assessment to examine treatment for, and recovery from, problem alcohol and drug use in 2010 (EADP, 2010) and another later that year on homelessness and problem substance use, which was published in January 2011 (EADP, 2011a). Following this, EADP initiated a consultation on its Draft Commissioning Plan for 2011-2014 (EADP, 2011b) and issued a strategy report later that year (EADP, 2011c). This set out the broad vision and three high level outcomes:

> 'We intend to be a city which promotes a healthy and responsible attitude to alcohol and where recovery from problem alcohol and drug use is a reality. This vision is supported by three High Level Outcomes which will be used to plan and deliver the strategy:
>
> 1. Children, young people and adults' health and wellbeing is not damaged by alcohol and drugs.
> 2. Individuals and communities affected by alcohol and drugs are safer.
> 3. More people achieve a sustained recovery from problem alcohol and drug use (EADP, 2011c: 3).

Further outcome indicators and intermediate outcomes were also provided in the EADP strategy document. Firstly, it proposed that the following indicators should be used 'to identify whether the strategy has delivered on the High Level Outcomes' (EADP, 2011c: 7):

- More adults report that they are drinking within sensible daily and weekly limits.
- Increased number of Alcohol Brief Interventions delivered.
- Fewer people report drinking to get drunk (binge drinking).
- Fewer people admitted to Edinburgh-based hospitals with alcohol-related illness.

- Fewer children required to be “looked after” because of their own or others’ alcohol and drug use.
- Fewer babies born suffering the effects of fetal alcohol syndrome, fetal alcohol spectrum disorder or dependent on illicit drugs.
- Alcohol-related crime and disorder is reduced.
- People feel safer in their community.
- Drug-related crime will be reduced.
- Reconviction rates for drug supply offences is reduced.
- By 2013 service users will not wait longer than 3 weeks between referral and treatment start.
- Professionals working in substance misuse services understand and support recovery.
- More service users complete treatment for alcohol and drug problems and move into recovery.
- Recorded alcohol/drug-related deaths are reduced.
- More service users and their families/carers are involved in the design, development and delivery of services.
- Increase in the number of people in recovery from alcohol and drug problems gaining employment.

Secondly, it is stated that the following Intermediate Outcomes are necessary to underpin the development of business plans to deliver on the strategy:

- Adults will drink alcohol more sensibly, less often and get more enjoyment within sensible limits.
- If they choose to drink alcohol, children will start drinking alcohol later in life, be well supervised and take fewer unnecessary alcohol-related risks.
- Fewer children will start to use drugs.
- Children will be less affected by parental alcohol and drug use and will be able to have the best start in life, be able to make and sustain relationships, and be ready to succeed
- Communities will experience less alcohol and drug-related crime and violence.
- People with alcohol and drug problems (and their families and carers) will access the right services when they need them.
- The treatment and recovery system of care will be based around the needs and aspirations of service users (and their families and carers).

EADP subsequently produced an 'Outcomes Menu'; agencies were invited to select from stated domains the outcome measures that they wished to prioritise in their work with service users:

Domain	Outcomes
Substance misuse behaviour	• ceased the use of illicit drugs (need to specify which) • reduced use of illicit drugs (need to specify which) • stabilised on methadone • reducing replacement prescribing • ceased replacement prescribing • reduction in the consumption of alcohol • reduction in binge drinking • not consuming alcohol
Physical and psychological health	• reduction in injecting risk-taking behaviour • improved sexual health • improved physical health • improved psychological health • Improved sense of wellbeing • improved personal hygiene • improved nutritional status • Improved dental health • Reduction in deliberate self harm • Reduction in A&E admissions
Social functioning and life context	• reduction in criminal activity • improved employability skills • improvement in employment status (moved into voluntary work, training, education or employment) • improved parenting skills • reduced chaos in daily living • improved personal relationships • reduced exposure to violence and domestic abuse • improved or sustained accommodation status (has a safe place to live) • improved financial situation • increased personal safety • person's social network with people in recovery is increased • increased participation in community activity
Personal Development	• increased motivation and feeling of responsibility • increased confidence and self-worth • increased self-efficacy • higher personal and career aspirations • increased resilience to set backs
Family / Parenting	• improved parenting skills • children attending school regularly • children are safe • healthy routines/boundaries are in place
Prevention & Education	• increased attitudinal change towards alcohol and harmful substances • increased community involvement in prevention activities • increased knowledge of the harmful affects of alcohol and drug use

Outcomes for carers	• improved personal relationships • improved or sustained accommodation status • increased confidence and self-worth • increased self-efficacy
Service outcomes	• more effective joint cross-agency working • increased access to a wide range of treatment and other therapeutic interventions • increased testing for BBV • increased service user involvement • Improved outcome measurement • Progress in redesign

Figure 2: EADP Outcomes Menu

ART and DRT staff chose to adopt the following outcome measures. (Confusingly, these are not the same as those reported in a Note of Outcomes Meeting, dated 5 December 2011, which was shared with the evaluation team, demonstrating that these measures are not fixed, and instead, are likely to be refined over time.)

Domain	**Outcome measure**
ART	
Substance Misuse Behaviour	Reduction in the Consumption of Alcohol
Social Functioning and Life Context	Improvement in Employment Status (moved into voluntary work, training, education or employment)
Social Functioning and Life Context	Improved or Sustained Accommodation Status
Social Functioning and Life Context	Improved Financial Situation
Social Functioning and Life Context	Person's Social Network with People not Misusing Substances
Service Outcomes	Increased Access to a Wide Range of Treatment and other Therapeutic Interventions
DRT	
Substance Misuse Behaviour	Reduced use of (illicit) drugs
Physical and Psychological Health	Improved psychological health
Social Functioning and Life Context	Reduced chaos in daily living
Personal Development	Increased self-worth
Family/Parenting	Children are safer
Service Outcomes	Increased access to a wide range or treatment and other therapeutic interventions

Figure 3: ART and DRT Outcome Measures

Two key issues that emerge here (that is, the complexity of the concept of 'recovery' and the challenges inherent in measuring outcomes) have resonance throughout this evaluation, as will be demonstrated further in the findings' sections.

3.3 Social Work Policy and Research

The 21st Century review of social work in Scotland, published in 2006, came up with three over-riding conclusions about the effectiveness of social work services. They were:

> *'Doing more of the same won't work. Increasing demand, greater complexity and rising expectations mean that the current situation is not sustainable:* Tomorrow's solutions will need to engage people as active participants, delivering accessible, responsive services of the highest quality and promoting wellbeing.
>
> *Social work services don't have all of the answers. They need to work closely with other universal providers in all sectors to find new ways to design and deliver services across the public sector:* Tomorrow's solutions will involve professionals, services and agencies from across the public, private and voluntary sectors in a concerted and joined-up effort, building new capacity in individuals, families and communities and focusing on preventing problems before they damage people's life chances irreparably.
>
> *Social workers' skills are highly valued and increasingly relevant to the changing needs of society. Yet we are far from making the best use of these skills:* Tomorrow's solutions will need to make the best use of skills across the public sector workforce, refocusing on the core values of social work. Social workers will need to make effective use of therapeutic relationships and find new ways to manage risk' (Scottish Executive, 2006a).

These conclusions carry a number of messages for social work in the field of alcohol and drug misuse. The first point relates to the need for flexible, responsive, personalised services already identified in the recovery literature. The second identifies the importance of multi-agency working, a central feature of this kind of practice, where social workers work alongside others from health, housing and other profession and agencies. A current Scottish government consultation seeks to take joint working even further, by fully integrating adult health and social care through a new law to create Health and Social Care Partnerships. The third point draws attention to the need to be clear when social work is needed, building from the use of relationships as the core of the social work task.

Galvani picks up these threads and more in her current book on supporting people with alcohol and drug problems. She argues that social workers have particular responsibility to respond to issues of substance misuse, because substance misuse problems are often linked with children and families' social work, with cases of domestic abuse and mental ill-health (Galvani, 2012). Social workers have a key role in protecting children and working with families affected by problem substance misuse (Scottish Executive, 2004, 2006a). Social work services are also central in supporting people with multiple and complex needs (which often includes substance misuse) (Scottish Executive, 2007; Scottish Government, 2009b). Galvani (2012) argues that the theoretical framework that underpins the social work profession is suited well to supporting people with substance misuse problems, since it considers the interaction of the individual with her/his environment: family, work and community. Recognising and addressing the social and environmental elements (e.g. what has been called 'social capital') are therefore essential to facilitating recovery (Granfield and Cloud, 2001; White, 2007).

Galvani and Forrester (2011) were commissioned by the Association of Directors of Social Work to look specifically at the role of social work services in recovery from substance misuse. They reviewed 57 studies of services for drug users and concluded that most used a form of case management. They identified the following important features in this:

- The form of case management offered should match the needs of the service users being worked with: the more complex the needs of the service user group, the more intensive and long-term the form of case management needs to be.
- The more serious the problems of service users, the more likely that case management will be beneficial.
- Approaches that focus on developing and sustaining a relationship appeared more likely to be linked to positive outcomes than forms of case management which focus on effective service coordination.
- Other common features of successful case management approaches included: limiting the number of service users per worker; an emphasis on creatively engaging individuals, e.g. through 'out-of-hours' work and interventions based in service users' homes or other places that they might attend; access to additional services rather than simply co-ordinating existing services; availability when needed, e.g. through 24-hour 'on call' services or long-term consistent availability; skilful communication and engagement, often argued to be based this on motivational interviewing or variations of this.

- In addition, there were said to be some promising social work interventions not based on case management, such as those involving family work.
- The outcomes for homeless people with mental health and substance use problems were found to be less positive (Galvani and Forrester, 2011: 6-7).

'Case management' is the principle method used by both ART and DRT, along with a strong emphasis on relationship and flexible working (seen in home visits, meetings in cafés etc.). Case management has been defined as 'the process of planning, co-ordinating and reviewing the care of an individual' (Hutt et al, 2004: 1). Beyond this, a good practice guide on case management published by the King's Fund identifies widespread confusion and uncertainty surrounding case management. Drawing from research evidence, Ross et al describe this as a 'targeted, community-based and pro-active approach to care that involves case-finding, assessment, care planning and care co-ordination (2011: 1). Unpacking this further, 'case-finding' is explained as identifying individuals most at risk (e.g. of future admission to hospital); 'assessment', it is argued, must be holistic, covering all aspects of a person's ability and needs; 'care planning' should provide a structure for the individual and the worker and involves making referrals to other agencies, co-ordinating services and monitoring progress; 'care co-ordination' is said to be necessary to keep all those involved 'in the loop'; it is about communication between patients, carers, professionals and services.

Strongly aligned to case management is the idea of 'brief intervention', another key aspect of ART and DRT method. Brief interventions in the field of substance misuse typically include assessment and feedback on substance use and its consequences. Advice and support is offered to aid the individual to change their behaviour, while accepting their possible ambivalence to change; brief interventions can consist of as little as one session (Carroll and Rounsaville, 2006: 227; Miller, 2006: 146). A well-known proponent of this approach, Di Clemente, argues that brief intervention, in conjunction with negative consequences or other significant events in a person's life, can 'increase concern, promote decision making, support commitment to take action, and offer some plan or behavioural actions that can help the individual accomplish some important tasks of self-change' (2006: 92).

Social work in general, as well as case management and brief intervention, will be re-examined in the discussion of findings.

3.4 Conclusion

This brief literature review highlights the significant pressure of expectations that is on an agency like the City of Edinburgh in terms of meeting need and delivering services for those with alcohol and drug problems. There has been a great deal of rhetoric about recovery in recent years, but little detailed research about how this operates in practice. Moreover, the thrust within policy makes a number of assumptions about the connections between day-to-day practice, ‘service level outcomes’ and ‘national outcomes’ that are difficult to substantiate. This evaluation will contribute to the growing body of knowledge on recovery, and at the same time, open for scrutiny a specifically social work response to alcohol and drug misuse, one which builds on ideas of case management and brief intervention, and which, in the present climate of performance management, is expected to demonstrate tangible, measurable outcomes.

4 Aims and Objectives of the Evaluation

The aim of this study was to carry out an evaluation of City of Edinburgh Council's Alcohol Referral Team and Drug Referral Team's services. It follows on from three previous studies: a needs assessment which sought to provide an assessment of local needs and gaps in relation to drug and alcohol services in Edinburgh (EADP, 2010); a review of the substance misuse needs of homeless people in Edinburgh (EADP, 2011a); and a cost-benefit analysis of DRT (Moody, 2010).

The study had two broad objectives. It sought to evaluate:

- Outputs (an evaluation of process – what was achieved?) and
- Effectiveness (how well was it achieved?)

4.1 Evaluating outputs

We were interested to examine both services-level outputs and those identified by service users themselves.

1) Services-level outputs

- What were ART and DRT expected to accomplish, as demonstrated in their policy and practice guidance and documentation? What were the services' objectives?
- To what extent were these achieved?

2) Service User-level outputs

- What did service users (past and present) identify as their individual objectives?
- To what extent did they think these have been achieved?

4.2 Evaluating effectiveness

This was explored through interviews with different stakeholders that set out to address the following questions:

- What did staff (managers and social workers) feel about the value and quality of the service?
- What did referrers feel about the value and quality of the service?
- What did service users feel about the value and quality of the service they had received?

In more detail, we were interested to find out:

- Why did people drop out or disengage and why were some people re-referred?
- Were service users better off after intervention from ART/DRT? Were there any negative or unplanned outcomes?
- Did ART and DRT services have an impact on others in the family of the user, especially on children? If so, what was this? Specifically, were children safer?
- Why did ART and DRT achieve the outcomes that it did? Were there any special features in the work that merited attention here (for example, home visits, 16 week programme, professional social work service)? Which other services do referrers refer people to, and why?
- Could/should anything be done differently? Any suggestions for future practice?

A copy of interview schedules is included in the Appendix.

5 Research Methodology and Methods

The evaluation used a mixed method approach (Nutley et al, 2003; Rossi et al, 2004), including both qualitative and quantitative methods:

- A targeted literature review of relevant national and local policy documents and research evidence.
- Analysis of services' reports and case-records.
- Participant observation.
- Focus groups with social work staff.
- Interviews with different stakeholders.

Three researchers from the School of Social & Political Science, The University of Edinburgh, worked on the project. One (Peter Hillen) conducted the participant observation, focus group and interviews with service users and staff, and led on the review of literature; another (Sumeet Jain) supported the focus group, conducted the DRT referrer interviews and led on the DRT analysis; the third (Viviene Cree) was the Principal Investigator. She conducted the ART referrer interviews and led on the ART analysis and led on the final report, to which all three contributed.

5.1 Methods

- Early exploratory meetings were held with the manager and team leaders to plan the evaluation.
- A brief review of literature and summary of relevant policies was undertaken to set the ART and DRT work in context.
- Information leaflets on the evaluation were drafted for all those who took part in the evaluation: staff, service users and referrers.
- Participant observation was conducted through shadowing social workers in their visits to service users (two from each service) to get a flavour of the direct work with clients.
- Two focus groups were held with social workers from both services.
- The team leaders of ART and DRT (including the senior social worker) were interviewed, as was the manager of both services.
- Case records were analysed.
    - We investigated basic demographic data, referral source and reason for closure in relation to all ART and DRT service users in 2011.

    - From this full sample, we looked in more detail at the outcomes of 50 of these, selecting every fourth case and analysing referral forms, care/action plans, case-notes and post-closure evaluations relating to these cases.
    - We also examined 10 of the evaluation questionnaires that were completed in 2011/2012 relating to ART and DRT clients from 2011.
- Structured face-to-face interviews were conducted with 10 current and former service users from each service, using standardised interview schedules and open-ended questions.
- Telephone interviews were conducted with referrers (those who refer in and those to whom the ART and DRT refer on), using standardised questionnaires (10 for each service); in two instances, the referrers opted to complete the interview as an online questionnaire.

All interviews with social workers and service users were audio-recorded and transcribed for analysis. Referrers' interviews were either transcribed or full notes were taken.

5.2 Sampling and recruitment

The technique for selecting informants for this study is best described as 'purposive': we approached specific groups of people who could tell us about their perspectives as individual 'experts' and as representatives of different stakeholder groups (see Oliver, 2006).

- Staff members all had the opportunity to express their views through focus groups and interviews with team leaders and the project manager.
- Referrers were selected at random from a list of all referrers from 2011; care was taken to ensure that different agencies and professional groups were represented in the selection.
- Service user informants were initially selected at random from the 2011 referral lists. Every 10th service user was contacted by the agency, given information about the evaluation and invited to take part. This produced some, but not enough, informants, and so another random selection took place, again using the same method. Finally, agency staff put forward a small number of additional names in order to make up our target numbers.

Three issues are worthy of discussion here: reliability and validity of the study as a whole, diversity in the sample, and service users' contact with children, identified as one of the priorities for both services.

Reliability and validity

This method of selecting service user informants might seem to bring into question the reliability of our findings, since we were only able to interview those whom staff could get hold of, and more crucially perhaps, those who then agreed to take part. Critics of qualitative research often question its reliability and validity; studies are accused of being too small, too specific, and interviews, in particular, are said to be too partisan. Our approach in conducting this evaluation has been to reject the notion that there can ever be absolute reliability and validity in research. Instead, we prefer to foreground the importance of methodological rigour as a means to achieving dependability and trustworthiness in our findings and analysis (see Lincoln and Guba 1985; Mishler 1990). This is demonstrated in our decision to adopt a process of 'triangulation' in the study, that is, in our use of different research methods and in our interviews with different stakeholders.

Just as it is never possible to know whether research informants are telling 'the truth', their answers will always reflect a range of factors, including their personal experience of the topic under discussion; their feelings about themselves; their views of the researcher; their lives past and present (see Katz and Mishler 2003). Furthermore, informants give access to their understandings of the meaning of something at the time of the interview; this is very likely to change over time, as new experiences colour their views and perceptions of events and feelings. Being aware of such reflexivity, in our view, strengthens the research analysis (see Finlay and Gough 2003). Building from this approach, we have not attempted to 'substantiate' or 'corroborate' anything which anyone has said to us, were that ever fully possible. Instead, we have heard and reported on informants' views as they stand, that is, as informants' views, with all the subjectivity that inevitably comes with this. This means that informants' views and opinions, as in all research studies, must be read critically; this does not, however, make them any less interesting or valuable. On the contrary, by piecing together accounts of different stakeholders with different viewpoints, we are able to build an interesting and complex picture of the issues being discussed and the services being evaluated.

Diversity

Although we only spoke to 10 former service users from each team, they turned out to be a surprisingly diverse group. We interviewed people from a range of backgrounds as well as those who were currently using and had used services in the recent past. Within this, we met some people who were very positive about the help they had received, as well as a number who expressed reservations about, and criticisms of, the services.

Informants were also diverse in terms of age and gender (though not ethnicity, as will be discussed in the findings' section. All but one were white European). The service users mirror the agencies' service users as a whole, demonstrating significant differences between the two teams in relation to ages of service users.

	ART	**DRT**	**Total**
Gender			
Male	8	7	15
Female	2	3	5
Age			
21-30	1	1	2
31-40	4	7	11
41-50	2	3	5
51-60	2	0	2

Figure 4: Gender and Age of Service User Informants

Contact with children

Service users who have contact with children (who may be living with them or not) are given priority in referral to both ART and DRT. Our service user informants demonstrated a range of relationships with children, from those who did have contact with children to those who did not. This worked out as follows:

- Three service users had children living at home with them;
- Seven had children lived with another parent;
- Two people had children who were looked after and accommodated elsewhere;
- Two had children who were over 18 and living away from home;
- Six people said they had no children.

5.3 Data collection issues

Difficulties with data collection impacted on the evaluation's findings in three important ways, affecting both the quantitative and qualitative data collection and analysis.

Quantitative data

These were incomplete in a number of ways, and where data existed, records were not systematically collected or presented in the same way. Problems with the data were partly a result of the different recording formats that social workers are required to use (SWIFT case-

notes, Carenaps and a care-plan proforma). This also, however, reflected the reality that different social workers have different styles of writing and recording, with some adopting a more narrative style than others. Case-notes also demonstrated the amount of engagement a service user has had with the agency; some case-notes were short and can be described as 'matter-of-fact'; others were fuller and gave a much more detailed picture of a service user's life and problems. Some social workers had gone back into care/action plans and provided an update. This was extremely helpful in enabling us to access information readily about how a service user had fared, however, this was done so only a minority of cases. In most other situations, an update was usually added to the case-notes, where it was less accessible (to the research team and, arguably, to social workers themselves). As a consequence of all these factors, the case records that were collected may not be wholly reliable in all instances; we have analysed as much information as was available.

Qualitative data

These must also be reviewed carefully. For example, post-closure evaluations with service users conducted by both ART and DRT are only carried out in cases of 'planned closure' (either at the end of 16 weeks or earlier, if the work is completed before 16 weeks). This inevitably means that there is no information or feedback available from those who chose not to continue to work with the agencies, for whatever reason. The research team did, however, interview a range of stakeholders – staff, referrers and service users – and these included some service users who dropped off the service, as discussed above. Within this group, we met a small number who were far from 'satisfied customers'. One of the ways that we were able to elicit critical views was by adopting a very open approach to the interviews (see Pawson and Tilley, 1997). Although an interview schedule was drafted in advance, the interviewer followed the leads of the informant at all times, and found himself in interesting and surprising discussion at times. This is illustrated in the findings' chapters that follow.

Timing of the evaluation

This evaluation took place in the first half of 2012, but the case-records analysis relates to the year 2011. During that year, significant changes took place: a new recovery worker was appointed and a 3RT worker began working on outcomes. Moreover, the EADP outcomes were imposed on DRT by Scottish Government at the end of 2011. In early 2012, a new initiative saw the introduction of 'recovery hubs' to Edinburgh, the first in South-East in January and the second in North-East in April 2012. Both hubs bring together alcohol and drug services provided by NHS Lothian, the City of Edinburgh Council and voluntary sector

agencies and offer new opportunities for inter-agency assessment and coordination as well as ‘drop-in’ for service users and staff. Our evaluation inevitably touches on some of these developments, as informants describe some of the improvements to the services. They also, however, make it difficult to accurately assess ART and DRT, since we are trying to pin down what is, effectively, a moving target.

5.4 Ethical issues

The evaluation project was assessed and given ethical clearance by the University of Edinburgh’s School of Social and Political Science ‘Research and Research Ethics Committee’ and by the City of Edinburgh Council’s Department of Health and Social Care research access team. The research assistant was given clearance to access client records on the basis of an enhanced disclosure report from Disclosure Scotland. A number of ethical issues were identified in planning and carrying out the evaluation.

Service providers may have felt anxious about having their personal work and their agency investigated. This was dealt with by being transparent about the purpose and process of the research by way of information sheets and regular, open communication with the staff involved. It was stressed to staff that the researchers sought to be fair and as objective as possible in conducting the research.

There may have been some anxiety within the staff team about sensitive information that they had shared in interviews or focus groups being disclosed to other staff. The researcher asked staff to read and sign a consent and confidentiality form to clarify that sensitive information would not identify them by name. It came to light that protecting the identities of team leaders and the manager could be problematic as these staff members are identified by their unique roles. It was decided that where sensitive information was revealed in the evaluation that, rather than specifying the type of staff member involved, a generic term would be used.

It was deemed that it would have been unethical for the researcher to ‘cold-call’ clients as they may felt uncomfortable or embarrassed. Because of this, staff were asked to make a preliminary phone-call to clients to introduce them to the researcher. This allowed the client to feel more at ease when the researcher called them. This may have improved response rates since the worker will have already had an established relationship with the client. On the other hand, it may have added bias to the recruitment process. Staff were given information sheets about the research to inform the clients. The information sheets made it

clear that participation in the research was entirely voluntary and if they did or did not participate, the service they receive from ART or DRT would not be affected. The same information was given the service users immediately prior to each interview. Each participant was thanked with a monetary voucher. Participants were asked if they minded if their interview was recorded. It was made clear that the recordings and notes would be held securely and confidentially by the research team.

Interviewing service users about substance misuse services and recovery inevitably touches on sensitive areas which may have caused psychological distress or discomfort. We approached this by stressing to participants that they would not be asked to share anything that they did not feel comfortable with. The focus of the interviews was on how services did or did not help and on the process of recovery rather than on an individual's personal experiences. The interviewer sought to engage with participants through empathic listening and had the benefit of previous experience and training in working with people with substance misuse problems. He was conscious of the difference between the boundaries of a 'research relationship' and a 'support relationship'. When sensitive issues that may have required support did come up, rather than taking on the role of supporter, the interviewer encouraged the participant to get back in touch with their respective worker for support.

For services users, as with staff, possible anxieties about confidentiality were dealt with through the use of a consent and confidentiality form. Service user participants may have still been involved in the use of illegal substances or involved in illegal activities. Illegal activity was not the focus of the questioning and it was not the role of the researchers to disclose illegal activity. The exceptions were stated clearly to the participant in the consent and confidentiality form: 'no information will be shared with the staff team of ART/DRT unless you tell us that you are at risk of harm or being harmed, or that you are harming someone else'. One particular ethical concern was about the possibility of disclosure about child abuse or neglect. It was agreed that if such information was encountered that the ART Protocol of Child Protection and Vulnerable Adults would be followed. Thankfully, no information of this nature was disclosed in the process of the evaluation.

5.5 Analysis

There is no single best approach to data analysis; instead, research questions and the purpose of data collection determine the nature and depth of analysis (Silverman 2004). The approach taken to analysis in this evaluation was, as demonstrated in the research methods,

pragmatic rather than theory-driven. All service users and service provider interviews were transcribed in full, allowing the research team to read and re-read the data in order to build a picture of what was being said. In addition, interviews with referrers were either fully transcribed or written up manually in note-form (see Alexiadou 2001). We initially planned to use the data analysis software NVIVO to assist in the management, sorting, organising and retrieving of data, but did not do so in the end, mainly because of time constraints in carrying out the evaluation. Instead we relied on tried-and-trusted thematic analysis (Benner 1985; Attride-Stirling 2001), looking for dominant themes, common threads, contrasts and contradictions in the data gathered across the two services.

5.6. Dissemination

A draft of this evaluation was shared with both ART and DRT before being finalised, and comments and feedback were incorporated into the final draft. Subsequently, the report was presented to a team of managers from the City of Edinburgh Council. Following this, the Executive Summary was sent to all those who took part in the evaluation. It is anticipated that articles drawing from the data will be written by the researchers.

6 Findings: ART

The evaluation sought to interrogate both *what* was achieved (i.e. outputs) and *how well* it was achieved (i.e. effectiveness).

6.1 Evaluating outputs

Outputs were investigated on two levels: at services-level and as experienced by service users themselves. In both instances, the relation between aspiration/identified outcome and actual output was examined.

6.1.1 Services-Level Outputs

What was the service expected to accomplish?

ART's documentation states that it is an adult social care service located within the City of Edinburgh Council Health and Social Care Department. It is set up to provide short term (16 weeks) focused work. Each client should receive a full community care assessment, a written action/care plan and holistic case management service. ART is a city wide outreach service and a home based service, although the client does have the option of meeting in other venues by negotiation. ART states that it will escort clients to first appointments to ensure engagement with the services agreed in the action/care plan. Three months after case closure, the ART Team Leader should arrange with the client to make a home visit to get client feedback on the ART service provided and whether the action/care plan is still operational. The Team Leader should then complete a re-referral to ART, if required. ART has no fixed office-base; ART workers use the facilities of Health and Social Care Centres across the city. ART sees itself as at the forefront of available technology through 'smarter working' designed to enhance the ART service and to maximise efficiency and value for money. ART should hold six-monthly Team Away Days to promote team building and operating effectiveness.

As already indicated, ART identifies the following outcomes for its service:

Domain	**Outcome measure**
ART	
Substance Misuse Behaviour	Reduction in the Consumption of Alcohol
Social Functioning and Life Context	Improvement in Employment Status (moved into voluntary work, training, education or employment)

Social Functioning and Life Context	Improved or Sustained Accommodation Status
Social Functioning and Life Context	Improved Financial Situation
Social Functioning and Life Context	Person's Social Network with People not Misusing Substances
Service Outcomes	Increased Access to a Wide Range of Treatment and other Therapeutic Interventions

Figure 5: ART Outcome Measures

To what extent has this been achieved?

Two sources of evidence were examined: firstly, all 'cases' (service user data) from 2011 drawn from SWIFT reports provided by administrative staff in ART, and secondly, a subset of 50 of these.

Analysis of all 2011 cases

Agency records tell us that 250 referrals were received in 2011; 18 of these were re-referrals and 232 were new referrals. Sixty-nine per cent (n=173) were male and 30% (n=75) female; in two instances, gender was not recorded. Most service users were recorded as white; only two were recorded as African or Caribbean, nine refused to give their ethnicity and in 27 cases, no 'race' or ethnicity was recorded. Almost three quarters (73%) of service users were over 40 years of age as outlined below.

Age	**No. of referrals**
16-20 years	0
21-30 years	8% (n=20)
31-40 years	18% (n=46)
41-50 years	36% (n=90)
51-60 years	24% (n=61)
Over 60 years	14% (n=33)
Total	**100% (n=250)**

Figure 6: Referrals to ART in 2011

The gender balance of ART service users is probably much in line with what we might expect of alcohol-dependent people in Scotland. Women with alcohol problems have

traditionally been smaller in number than men, and have been less likely to seek help with alcohol misuse. However, recent research from the US and the UK suggests that more young women are experiencing problems with their alcohol use (e.g. Grucza et al, 2008) and this may require a new response to female service users in the future.

The low number of referrals of BME service users is particularly noteworthy. A consultation on substance use and addictions in black and minority ethnic communities in Edinburgh conducted between 2005 and 2006 stated that alcohol and drug misuse affected all communities in Edinburgh, and expressed concern about the lack of services and training for social workers in this area (EMEDI, 2006). It also highlighted that alcohol misuse is a greater problem for BME people than misuse of other drugs. More recently, a review conducted by Hurcombe et al (2010) identified that although levels of alcohol use were lower and abstinence higher amongst those from BME backgrounds in general, when those with a Muslim or Pakistani did drink, they did so more heavily than other non-white religious or ethnic groups. Again, this is an issue that merits further attention by ART staff.

The last point to be made here concerns age. The fact that so many of those who are referred are in their mature years reflects the reality that ART seeks to work with those who have a serious problem with alcohol. It also, however, implies that for many, alcohol has been a feature of much of their adult lives, leading to considerable physical and mental health difficulties, as the interviews with service users will demonstrate. Research highlights two important factors here: firstly, that older people are more likely to drink heavily alone, and people's capacity to tolerate alcohol reduces with age (see Galvani, 2012). Both issues are likely to be significant for ART.

Agency records also give the stated reason for ending contact with the service users with whom the agency worked in 2011. Contact was ended with 276 service users during that year; in only 35% of cases (n=98) was this recorded as 'work complete' (see figure below).

End reason	**No. of closures**
Closed at service user's request	42
Inappropriate referral	7
Lost contact with service user	34
Not recorded	37
Service no longer required	47
Service user admitted to hospital	3
Service user deceased	3

Service user moved out of area	3
Transfer to another CEC team	2
Work complete	98
Total	**276**

Figure 7 Reason for Ending (ART)

There are a number of observations that can be made about this information. The first is that it is rather inconclusive, if not wholly confusing: why are 37 cases reported as 'not recorded'? What should we infer from the 47 recorded as 'service no longer required'? Were these agency successes or not? It is impossible to tell from the current recording systems. And why are so many (42) 'closed at service user's request'? Again, does this infer the service was no longer required, and if so, why is this a separate category? It is clear that for this information to be useful to the agency, the 'Reason for Ending' record needs to be amended so that it is more fit-for-purpose. It is also interesting to note that three service users died in 2011, again highlighting the age, ill-health and seriousness of the problems of ART service users.

Analysis of 50 cases

Fifty service reports were examined in greater detail, drawing on referral forms, care/action plans, case-notes and post-closure returns and building analytical themes from this.

Information on sources of referral suggests that most referrers in this cohort were from a health background (16 community based health, seven GPs and another seven hospital based health professionals made referrals). Ten referrals were received from social work colleagues in Health and Social Care or Children and Families. One is recorded as 'local authority other' and nine are also 'other' (unspecified). It seems likely that voluntary sector agencies, police, prison services are in the group, but there is no information to confirm this. (DRT specifies more categories and so has more information on this.)

The process of analysing the case-files in more detail was not straightforward. Records were incomplete: although reports provided extensive information about identified needs, they did not always explicitly record planned actions and outcomes. Of the 50 cases analysed in detail, only 11 clearly recorded outcomes. (See further discussion of data collection in section 5 on Research Methodology.)

Reviewing the evidence from the case records, it is difficult to draw a connection between support needed and support provided (see figure below). In some instances, information about support needs will have been gathered at referral or initial assessment stage, but the service user may not have engaged any further. Significantly, out of the sample of 50, only 24 service users engaged with ART for the course of the 16-week programme; six had no engagement with the programme after referral; 12 had minimal engagement (categorised as one to three meetings). Two constituted 'unsuitable referrals'. Three clients rejected the service after referral and three died.

	Support needed	**Support provided**
Problem/concern	**Citations**	**Citations**
Addiction problems	74	31
Child protection concerns	7	4
Family problems	5	0
Financial problems	18	14
Housing problems	24	17
Legal problems	1	0
Mental health/ well-being	35	10
Offence-related problems	12	1
Physical health/disability	43	22
Social problems	24	9

Figure 8: Support needed and provided - 50 cases from 2011 (ART)

Notes:

- In all situations, more than one support-need was identified; hence the total number of citations is greater than 50.
- 'Addiction problems' covers a range of identified needs, including alcohol (50), drugs (17), detox and rehab (4) and relapse prevention (4).
- Housing problems includes help required with homelessness and tenancy support.
- Most citations in the mental health/ well-being category were listed as 'mental health' but this broad category includes one citing of 'cognitive impairment', one of 'bereavement', two of 'anger issues', two of 'emotional problems' and two of 'sexual abuse'.
- Physical health/disability includes five citations of HepC or HIV.

- Social problems are taken to cover education, employment (paid and unpaid) (eight), general/life skills (two); and ‘social needs’ (14).

A number of observations arise out of conducting this exercise. The first is that it was extremely difficult to categorise either the support needed or the support provided, because the agency uses different terms for similar things and the data are recorded differently by different people. There are also many gaps in the records, so it is impossible to be certain in many of the situations that ‘x’ service user had ‘y’ needs and that these were met in ‘z’ ways. This is, of course, the nature of addictions services: clients never simply have one problem (as our figure suggests), and many service users disappear before the end of programmes (some do not engage, some drop off along the way, and some even die, as our other data illustrates). Hence, the figure demonstrates problems inherent in data collection and analysis for this group of service users. (This is discussed further in Section 5 on Research Methodology.) It also, however, suggests that more could be done to standardise recording, since social workers are currently using multiple electronic systems and forms for recording outcomes.

Setting to one side the technical flaws in the data, important findings emerge nonetheless. Firstly, alcohol problems (as already stated) were demonstrably accompanied by a range of other problems (this will be picked up in the interviews with service users). Secondly, physical health and disability issues featured prominently, as did concerns around mental health and well-being. Issues around housing/tenancy/homelessness were common in this group of service users, as were social needs, from a variety of aspects. Interestingly, in a significant number of cases, drug misuse was recorded as well as alcohol problems. Family problems and issues around child protection were low in the list, indicating that for many service users, family life had broken down and they were effectively on their own.

A closer analysis of cases representing service users who fully engaged with the programme provides further illumination (see figure below). In this cohort of 50, 24 either completed the full 16-week programme, or completed the work identified in less than 16 weeks. Within this group of 24, there were 31 citations of support needed for physical health and disability and 21 citations for support required for mental health problems. However, there were only 20 citation of support provided for physical health problems and 7 citations of support provided for mental health problems. It seems likely that others may not have been ready or willing to engage, or this may reflect a lack of services for ART to refer on to, particularly for those with mental health problems. In contrast, of the 13 who sought help with financial difficulties, all

received help with this. Housing, likewise, was an issue that affected 17 service users and 15 are recorded as receiving support with this.

	Support Needed	**Support Provided**
Problem/concern	**Citations**	**Citations**
Drug misuse	8	0
Alcohol-related problems	30	26
Child protection concerns	2	2
Family problems	4	0
Financial problems	13	13
Housing problems	17	15
Legal problems	1	0
Mental health/well-being	22	7
Offence related problems	5	1
Physical health / disability	31	20
Adult Protection	0	0
Social	18	8
Total	**151**	**92**

Figure 9: Support Needed and Provided to those Fully Engaged (24 cases from 2011)

6.1. 2 Service User-level outputs

Interviews with service users demonstrated that clients had a range of objectives and expectations of what might be achieved by working with ART; they were also clear what the outputs of the intervention had been, and, in one case, not been. The sub-headings used are based on the accounts of service users. These broadly reflect the themes emerging from the sample of 50 case files above, although there has been no attempt made to 'attach' one service user to one case-record. Not only would this have been impossible given the approach taken to quantitative data-gathering (where every fourth case from 2011 was selected for detailed scrutiny) but it would have interfered with our wish that service users' accounts should stand as evidence in their own right, untouched by agency perceptions.

The service users have been identified only by letters of the alphabet chosen by the research team to protect their anonymity; all staff mentioned have likewise been anonymised.

What was the service expected to accomplish?

Alcohol problems

Interestingly, only three of the 10 service user informants stated that they wanted help from ART with their alcohol problems. This was in spite of the fact that alcohol misuse had created havoc in their lives (seen in homelessness, disrupted family lives, court cases and, in some situations, imprisonment). All had, currently or in the past, a worker whose focus was alcohol; CPNs, doctors, alcohol counsellors and an OT were all mentioned as those whose main task was to work with them on their alcohol issues. Those who wanted ART to help with their alcohol use were also making use of a number of agencies at the same time in relation to this (see below, Patchwork of Agencies).

Health problems

Almost all informants described serious health problems, including physical and mental health needs. For nearly all of the service users interviewed, a lifetime of alcohol misuse had taken its toll (most had been drinking heavily since their teens or early 20's and were by now in their 40's and 50's) and they suffered a range of chronic health problems as a result: liver damage, heart problems, asthma and diabetes were common. Service users also spoke a lot about mental health problems, most frequently depression, but also psychosis and post-traumatic stress disorder (in two instances). Although the informants all spoke about these difficulties as central to their lived experience, they did not tend to see these as concerns that ART could, or should, address directly.

Financial problems

These covered a great many areas: problems with rent arrears, council tax arrears, other debts (service users often had fuel debts, for example), problems with banks, mortgages and bankruptcy. Many wanted help with applying for welfare benefits. The forms for Incapacity Benefit and Disability Living Allowance were seen by all as obtuse, difficult to understand and very long. But financial problems were not simply experienced as stand-alone problems; on the contrary, they impacted on all other areas of life.

Housing problems

These were a feature for many service users who began with ART at the point of transition, often from hostel to council or housing association flat. Some sought help with re-housing; others with mortgage or rent arrears; one man B (aged 45) had had a serious breakdown in his relationship with his housing association landlord and he wanted ART to sort this for him.

Issues around access to children

These were also a feature in service users' narratives. Both women who took part in the study had had experience of their children being 'looked after'; in one case, the children were now living with grandparents, in the other, the child was back at home again. Six of the eight men had children, and all but one talked about breakdowns in relationships with their partners and children. However, only one man, J (aged 34) said he hoped that ART could help him get access to his 6 year-old daughter.

Low self-esteem and social isolation

These were experienced by all the service users we spoke to, one way or another. Many had lost contact with key people in their lives – partners, children, siblings, friends – though a few did still have regular contact from siblings and parents (54-year old H told us that his 85 year old mother still bring him meals and tidies up for him). Most said that they found it difficult to leave the house, and were uncertain in a new social situation. Many, notably, said they didn't like discussing their problems in groups, hence preferred the one-to-one support offered by ART.

To what extent has this been achieved?

Eight out of ten of the service users we interviewed were happy overall with the outcomes of ART intervention in their lives. Most were extremely positive and grateful for the help they had received. One (E, aged 43) felt that the timing had not been right for him, and he was disappointed that ART could not provide someone 'to help me tidy up a bit'; another (B, aged 45), who expressed negative views about ART, probably had unrealistic expectations about what might have been achieved. He said:

> 'I was under the impression that social workers could move mountains but they actually created molehills everywhere and undermining the very fabric of the ground we walk on.'

Alcohol problems

All the service users were working (or had worked) with others to address their problems with alcohol, and for most, this meant medical practitioners of one kind or another. Nevertheless, ART played a key role at particular times in people's lives in referring them on to others for treatment (at both inpatient and daycare services) and support (from statutory and voluntary agencies). For example, D, aged 52, was clear that the ART worker had played a key role in 'helping me to get me off the drink' by facilitating his admission to hospital for detox. Following this, the ART worker turned his attention to other areas of his life, including finance and fitness/well-being.

Health problems

ART is not a health service and therefore this was not an outcome service users expected of it. However, the ART workers made a great many referrals in relation to broadly health-related issues, to treatment and support agencies (as above). The workers also spent considerable amounts of time talking with and listening to service users, and this was valued as a great resource to draw on. In one instance, A (aged 45) phoned the ART worker threatening to self-harm and she called the police; this was seen as a major help at a very difficult time.

Financial problems

For many service users, getting finances in order was a welcome outcome of ART involvement. ART workers referred people on to Citizens Advice and the Advice Shop and also gave help themselves, for example, with applications for welfare and housing benefits. Practical help and advice included everything from form-filling to making phone-calls and explaining how systems work. Service users appreciated that ART social workers had expert knowledge (about benefits etc.) that they didn't have, and were willing to share it with them. For example, D said: 'At the time, there were problems with me, like I fell behind with my electricity, my gas and all that. They helped me get that fixed out. They got all that fixed out for me. Now I get money taken off my benefits every week. It goes straight onto my gas and electricity.'

Housing problems

ART supported service users to apply for tenancies and helped them to put in place ways of paying back rent or mortgage arrears. Sometimes they were able to give information and advice themselves; on other occasions, they accompanied service users to Citizens Advice or housing agencies. This support (called 'hand-holding' by I, aged 50) was highly valued by service users; he described this as follows: 'Just the fact that there's somebody there to go

along someplace, the first time you attend somewhere, makes a huge difference. It's not such a mountain to climb.'

Issues around access to children

This was again, an issue that ART workers referred on to others, predominantly Citizens Advice, so that the service user could get legal advice, or the local authority social worker. In one instance, a female informant F (aged 28) said how important it was to have a relationship with the ART worker because she refuses to speak to the local authority social worker who took her children away from her; she said speaking to the ART worker 'gives me someone else to talk to and new ways of thinking'.

Low self-esteem and social isolation

All service users (with one unhappy exception) spoke about how important it had been to them that the ART worker was willing to take time to listen to them. They felt that their story had been heard; they felt someone understood and valued them, often for the first time in a long time. For example, H (aged 54) said: 'They actually listened. They went out of their way to say 'fair enough'.'

ART workers also spent considerable amounts of time trying to increase service users' social capital, through building a structured programme of activities through the day, including encouraging them to take part in computer classes, creative arts, college attendance, drop-in centres and groups of various kinds, as well as volunteering as a possible route back into employment. Eight of the ten service users said they appreciated the help they had received in bringing some structure to their lives. One person said he had been drinking '24/7; whenever I was awake, I was drinking' (D), but the ART worker had helped to shift this. He said: '… the boy was good. He helped me out, got me back into sports and things like that'. Other said they had had help with preparing CVs so they could apply for work. It was evident from some accounts that not all of the options explored had been taken up at the point of interview. However, the service users said they were better informed about what they might do when they felt ready to do it.

6.1.3 Conclusion

ART service users are, on the whole, an older client group, predominantly white with a range of complex needs (as will be picked up in the next section). Child protection does not feature as highly as might have been expected, reflecting the age of service users. The evidence suggests that the agency addresses a range of issues and provides support in terms of referral, advocacy, emotional and social support and information and advice. The sample of

24 service users who had completed the programme said that they had been helped, in sometimes small, but always realistic ways; the interviews with 10 service users confirmed this. Evidence from wider research suggests that ART could be doing more to work with young women and to address the needs of the BME community.

6.2 Evaluating effectiveness

We have so far focused on a discussion of what was done; whether this was done well, and how well, is a much more difficult set of questions to answer. Making an assessment about whether or not a service is 'effective' demands a clear statement about how effectiveness is being measured and by whom.

As outlined earlier, the Framework for Action (Scottish Government, 2009) calls for sustained action in four areas: reduced alcohol consumption; supporting families and communities; positive public attitudes, positive choices; and improved treatment and support. This is a very broad agenda for action. EDAP's priorities are also discussed in the literature review. Three 'high level outcomes' are followed by a list of further indicators and intermediate outcomes. These cover everything from alcohol-related issues to broader individual, family and social targets. To identify ART's goals, we turned to the ART Guidance for Referrers. This is headed, 'To reduce the effects of alcohol misuse on individuals within Edinburgh communities'. This suggests that from an ART perspective, 'effectiveness' might be a reduction in the effects of alcohol misuse on individuals within Edinburgh communities. With so many aims and objectives and so many competing targets, from the highly aspirational down to the minutely detailed, it is inevitably difficult for the agency to demonstrate that it has been effective.

In the end, we opted to examine two sources of evidence for effectiveness. The first was a detailed analysis of service user evaluations selected at random. These are the evaluation questionnaires that are administered to all those who complete the 16 week programme. In ART, the Team Leader goes out to see people three months after the case has been closed, and seeks their views about levels of satisfaction with the service received, about feedback on staff and relationships, and about any improvements in the service user's quality of life. Since a questionnaire is used, the service user evaluations provided both quantitative and qualitative evidence.

The second source of information was interviews conducted with staff: manager, team leader and a focus group with social workers. This was followed by telephone interviews with referrers and face-to-face interviews with service users.

6.2.1 Service user evaluations administered by ART

Of the 50 cases in our cases sample, 11 had a post-closure evaluation completed, and 10 were selected and analysed.

The ART evaluation asks former service users to ‘list the services/resources the ART social worker helped you to access, or tasks he/she helped you to complete’. Each mentioned between two and six services that ART had helped them to access. These included services addressing substance misuse, disability, employment, volunteering, housing, criminal justice and health. They were also asked, ‘would you have accessed these services without the help of the ART social worker?’ All of the clients in the sample said they would not have accessed these services without ART’s help.

In the ART evaluation, the main questions that relate to maintaining recovery are as follows:

- Have there been any positive changes in your alcohol misuse as a result of ART involvement?
- How much closer do you feel you moved towards your goals?
- Has your quality of life improved in any way since ART involvement?

In our sample of questionnaires, eight out of 10 people said that there was a positive change in their lives as a result of ART involvement. Four said they were now abstinent. One said, 'Been alcohol-free for 4 months. I am still alcohol free and feel confident I will remain like this - without [ART social worker's] help I would not have accessed rehab and she made it easy for me to do this.' Two said they had more control over their alcohol consumption and had reduced their amount. One person said that while he was still drinking, he was closer to his goal of abstinence. Overall, five said they were ‘significantly’ closer to reaching their goals; four said they were ‘somewhat’ closer, and one said ‘no change’. Seven agreed that ART had ‘significantly’ improved their quality of life; one said ‘somewhat’; one said ‘no’ and another person indicated improvement indirectly. One person was fulsome in his praise. He said, ‘Life completely changed. I have managed to get through Christmas without hospitalisation and am looking after myself even losing weight. I look forward to the future now'. The person who saw no change expressed that he would have done better if he had

the service for longer, 'Should have had him longer as I relapsed quickly after he left. I am nearly at the stage of stopping drinking again when ready'.

People were also asked to what degree the social worker's approach had affected their motivation towards change. All agreed that this had been an important factor for them: eight 'significantly' and two said 'somewhat'. One person said, 'She was the person that got me my new tenancy and this means I am in a good position to stop drinking'. Another said, 'Without [ART social worker] coming to see me and giving me the confidence I could do it, I would not be alcohol-free and given my self-harm in the past, I may not be here now'. A third said,' [ART social worker] was great - she showed me respect when no one else did, not even my family and she really motivated me in a way no-one else ever did because she treated me like a human being and not a drunk'.

Asked what they liked most, former service users gave a range of answers, from knowledge and skills, to encouragement, support to attend visits, 'a positive attitude, care and professionalism'. One person said, 'I liked that she dealt with what was on my agenda'. Three people mentioned the importance to them of home visits. Another three spoke specifically about the friendliness of the social worker. One said, [ART social worker] boosted my confidence and helped me feel I could do things and make changes'.

When asked, 'what did you like least?', six of the 10 former service users said that they would have had liked the service for longer; one suggested 32 weeks would have been better, and another recommended six months. Two made no comment at all and another two had only praise for the help they had received. One said he would 'advise others to use the service'; another said, 'nothing at all it was brilliant'.

6.2.2 Staff views

ART's ethos and services

Staff members were clear that the ethos of ART is about providing a person-centred, flexible service that is home-based. The Team Leader explained, 'What we are looking for is a reduction in the harmful behaviour related to their alcohol use'; […] 'in layman's terms, you're trying to help somebody move their life on'. Another social worker said that it is about 'giving structure to people's lives'. But this had to be on the service user's terms. As a social worker stated, 'it's about enabling service users to take more control of their lives, as opposed to being a service that *does to* people'. She continued, 'I think timing is all-important in terms of

referrals to our service and then the service users being ready to move forward and that we do it at the right time, at the right pace, and that's a pretty crucial part of the underlying philosophy of the service'.

Staff all stressed the importance of ART being a 'social work' service; one that sees the person in the context of their families and communities. Its location in the City Council gives it easy access to all other council services, from mental health to children's services, and this is seen as beneficial by social workers. It is also a service delivered by qualified social workers, which again is viewed as a 'plus' by staff, since they have shared training in key issues including child and adult protection. All agreed that building a good, empathetic relationship with service users was at the heart of their practice, as supported by both social work literature (e.g. Ruch et al, 2010) and by substance misuse research (e.g. Meier and Donmall, 2004). One social worker explained, 'it's also building up that relationship as well, when you go in, you're going into vulnerable people's lives who are quite often […] in a crisis situation, and alcohol is very low on the priority list' (this point will be picked up later in the data relating to service users).

Recovery

'The recovery journey', explained the Team Leader, 'starts with the assessment and looking at the person… but it's a holistic approach to assessment, where we look at the entire person, both personally, as a family, socially, psychologically, physically, right across the board. We, then, bring that together as a plan'. He outlined 'recovery' from his perspective:

> 'Recovery means getting the person […] to the position where they feel their life has moved on, where there has been either a stabilisation of the situation, however they might define that, or an improvement in the situation. It's taking the steps to a life and lifestyle that they are more comfortable with. […] it can be the full thing, it can be abstinence, it can be going back to work, it can be all of that, or it may be the mere fact that they are able to control their level of drinking and they're able to re-establish contacts with other friends and family and that's a much more solid relationship. That might be as much as somebody can manage, because we've worked with everybody, from people who have got learning disabilities, physical disabilities and the majority have either diagnosable mental problems or some level of depression.

In the focus group, there was a lengthy discussion about abstinence and recovery. One social worker said, 'everyone's recovery journey is different and I think in terms of what recovery means to me as their worker would be, it's a normal process and in some people it may last many, many years and for somebody, it might be the substance misuse first and

then looking at how you can build on that'. Another social worker added, 'I think recovery is an ongoing process and it can be very small steps or somebody can go from us straight to rehab and succeed through a residential rehab'. For other service users, however, the best they will achieve is management of alcohol; their goal is to become a 'social drinker'.

The issue of abstinence is inevitably a challenging one, for service users and for staff. ART is not, unlike other health agencies, focused on abstinence. This may cause tensions for the ART social worker in a situation where, for example, a Children and Families' social worker may wish to recommend to a Children's Hearing that a parent or couple must achieve abstinence for a child to be returned home. The ART social worker has to communicate this view, while at the time wanting to encourage the service user/s to achieve the best they can in their own way. This means, for ART, 'getting it right for the *parent*' (to use the Scottish government's strategy 'Getting it Right for the Child'), with the understanding that children will not be helped unless parents are also given support.

Complex needs

This leads us to a discussion of complex needs. ART staff told us that while they take the government's definition of complex needs into account at referral stage and in assessing cases, but they do so very broadly. The Team Leader feels that ART is effective in this area, as demonstrated by the evaluations he conducts three months after closure.

Service users

Staff described working with a range of service users, with a wide variety of problems. One social worker said that he was surprised when he started work at ART at the kinds of clients he was working with. He said, ': You know, you have got some very low functioning people who are really struggling to even open the door, but we've also got some very high functioning people, including [professional people]'. Asked who was most challenging to work with, staff agreed that it was those with mental health problems, with learning difficulties and 'high level' personality disorder, thus reflecting the evidence of Galvani and Forrester (2011). However, difficulties with service users were also compounded by the lack of other resources on which to draw, or on the waiting lists of other agencies, which meant that help (e.g. detox) could not be received in a timely way and so the problems experienced by service users worsened.

The nature of ART service delivery

All staff agreed that being an office-less service did nothing to diminish to quality of service provision; instead, it allowed for more flexible working, and, crucially, the appointment of two

additional workers (feedback from Team Leader). Social Workers said that they felt that home visits and 'being able to meet service users where they are' is central to the agency's success. Home-visiting is regarded as beneficial for those with health and mobility problems, and also welcomed by more middle-class clients who might not be willing to attend an alcohol project on, for example, a housing estate. A direct outcome of home visiting is that there is a low rate of those who 'do not attend' (it is 20-30%), as compared with other alcohol agencies whose rate might be as high as 50% (as reported by the Team Leader).

There was ambivalence from staff members, however, about the 16-week time limit. Whilst everyone who spoke to us valued the targeted approach, built on relationship and encouraging motivation, many said that for some service users, 16 weeks was not enough. The Team Leader admitted 'If you're talking about a recovery journey, we're often the beginning of this recovery journey, but we never get to see the end of it'. A social worker added, 'Because people often have complex needs, it takes a while to really engage with them, because they are not really the easiest kind to engage with necessarily, and sometimes by the time you're nearing the end of your 16 weeks, you really have a good working relationship with them'. Social workers cope with this, at times, by continuing to work with service users beyond the 16 week period, or by phoning to check up on their former clients after the programme of intervention has been completed. All agreed that they would welcome greater flexibility here.

Strongly negative views were expressed about the IT equipment that the social workers must use: 'dreadful IT', 'dreadful IT support', 'Stone Age equipment' were the words used to describe this. One person added, 'It's an absolute major burden to us, the fact that the IT is so time consuming, so unreliable and completely pants'.

<u>Work with other agencies</u>

ART staff also agreed that it would be rare for ART to be the only agency involved in a service user's life. Instead, the ART task is to do a full assessment, then create and hold the package of care together for the time of the intervention. This everyone, agreed, is the 'social work' role – assessment, action planning and care management. It is also the social worker's job to keep everyone working together, as one social worker explained:

> '… whenever I have a client who is working with other professionals, I always set up three-way meetings, like next week I'm meeting with a woman […] whose baby died. I'm meeting with her, the nursery, because she has another baby, another child, so meeting with the client, the nursery and the Children and Families' worker. I always try to set up these three or four way meetings to build those relationships as well,

> because we're all, we're not seeing each other on a regular basis, just to make sure we are all on the same page and what their agenda is, is linked to what my agenda is, so everything can be kind of synchronised that way.

All staff were enthusiastic about the development of 'recovery hubs' in Edinburgh, where health services, local addiction voluntary agencies, ART, DRT and other agencies all operate from within the same building. This allows a 'drop-in' facility for the first time, and reduces waiting times and facilitates communication between agencies and workers. It will also reduce the time spent travelling across the city by social workers, and this was welcomed by all.

One idea that emerged in discussion was the suggestion that ART and DRT might come together as one agency in the future, with one or possibly two teams within this. Whilst no-one ruled out this idea in principle, views were expressed that alcohol and drug addictions are quite different in presentation and substance, so that specialist skills will still be required.

6.2.3 Referrers' views

All ten referrers who took part in the evaluation were very positive about the services that ART delivers. They saw ART as providing a unique and valuable service within the mix of services for those with alcohol problems in the city, and they all agreed that ART social workers were well-trained and professional in their approach.

<u>ART's ethos and services</u>

Interestingly, 4 out of the 10 referrers interviewed found it difficult to pinpoint what ART's ethos is, suggesting that either the notion of 'ethos' is a tricky one or that ART could do more to communicate this to others, or both statements may be true.) Of those who were able to answer the question, the words 'holistic' and 'person-centred' were most frequently used, followed by the word 'professional'. It was suggested further that ART offers a 'holistic assessment' and a 'broad base of support'. One of the GP's interviewed was fulsome in his praise. He said,

> 'Holistic. Pragmatic. Realistic. Non-judgemental. Open-minded. Flexible. It provides an important alternative or adjunct to the medical model. […] It provides an open-minded and realistic approach to de-constructing problems and finding solutions outwith the boundaries of medicine, and as such, offers solutions to social problems which provide much better outcomes than a prescription pad ever can. It encourages self-empowerment and lets individuals regain a positive outlook.'

A CPN referrer was equally positive in her appraisal of ART's services, which she identified as 'case management'. She continued,

> 'They look at you as an individual with all aspects of your life, not just alcohol or substance use – they will also look at your housing, your benefits, how you spend your time and they will endeavour to provide a package of support that when they withdraw, will continue to support you in all the areas that you have identified as having needs. They do 'big picture work', rather than like professional services like ourselves that just focus on just one issue.'

Recovery

All referrers were invited to comment on how far ART facilitated people's recovery from alcohol misuse. This elicited interesting discussion about recovery – what is it? At what point do we know for certain that someone has 'recovered' from an addiction? The question also threw up some observations about the service, and in particular, how difficult it is for ART to identify and communicate its successes to others.

In more detail, some referrers were able to explain what they saw as ART's role in recovery. A social work referrer explained that ART was 'not always about abstinence; it might be about finding a safe level to drink, so it's not doing the damage it was before, but they don't have to abstain completely.' A social work referrer agreed, saying,

> 'I understood that they're not actually trying to - they're trying to help individuals manage their drinking, that's what I understand. Recovery, well, we'll only see if we refer someone if they come back through our service. I have to say they have been successful with quite a few people. There's names that will come in on police referrals that we'll know on a day-to-day basis but, yes, I would say there's a lot of the names that have not come back after referral. That's fantastic.'

A GP referrer expressed recovery in terms of 'helping stabilisation of more chaotic individuals'. Others felt that ART does help to 'move people on in the direction they want to travel' (two social workers said this) and that this is, in itself, a measure of recovery. A second GP, commenting about both ART and DRT, stated that where the outcome had been less positive, the 'issues or barriers were with the patient rather than ART or DRT'. He continued, 'I know several patients who have gained everything they needed from both ART and DRT.' One voluntary agency worker stressed the need for flexibility in thinking about recovery:

> ‘I think it’s about having – and I think they do have – a flexible adaptive approach to working with service users because we know that people do relapse and recovery is all about them maintaining contact with services – and how they get back into a service like ART. It’s also being flexible about how long they work with ART. I also think it’s about appropriate flexible working – for one person, a month might be enough; for others, it might be months, so it’s about how they can work with people’s individual needs, and if need be, someone gets referred again if that fits with what they are needing. […] It’s about meeting people’s needs and these are ever-changing – and so services need to change to meet this too. It’s about context and an ever changing role for us as addictions workers – and a changing role for ART and DRT, now that we have both.’

One referrer, a CPN, expressed disappointment that ART staff had not fed back to her how those whom she had referred had fared; this made it difficult for her to comment on the team’s effectiveness in terms of recovery. A hospital nurse agreed that she had made a referral and after this, had had no further contact, with either ART or the patient, so did not know if the patients had even taken up the service’s offer of help. Again, this point was picked up by one of the GP’s, who said that ‘updates on progress or information on objectives identified as needs expressed always helps build a coherent on-stream message for patients’. He understood the difficulties in achieving this, however:

> ‘When patients say they are meeting with x (ART worker), I’ll often ask what the aim of the next meeting is or what work is being covered, but I wouldn’t want patients to start thinking that we’re not communicating with one another (if that makes sense). However, other than firing off emails to each other (between the referring clinician and the ART/DRT worker) I can’t really see a solution, and as stated, the time limitations on both sides can make this a fine balance to achieve.’

There is an important general message here about communication and ‘joined up working’ (see also Working with Other Agencies below). But the criticisms also allude to the nature of the referrers’ own work (GP’s have ongoing contact with their patients; others may not) as well as the difficulties of judging an end-point in terms of recovery. Nevertheless, there is a clear recommendation that ART could take forward here.

Complex needs

Referrers were also asked to comment on ART’s effectiveness in supporting individuals with complex needs. Interestingly, two referrers said they did not work with people with complex needs; a third added that those she worked with tended to have either alcohol or drug

problems, but not both. In contrast, one said that everyone she worked with had complex needs, and another agreed that ART was 'particularly helpful in helping to stabilise/support complex patients'. One referrer stated that because of their complex needs, it was important often to refer people to a range of services, including ART and their GP.

One referrer felt that ART's effectiveness in this area was mixed. She said, 'I think the people they engage well with do very very well; but I sometimes feel that they struggle to engage with some people'. She wondered if they could do more here, for example, more joint appointments with other agencies. But she added that she had been 'very impressed' overall.

Two referrers commented on the fact that there are now two services, ART and DRT, and wondered if it would make more sense for there only to be one, especially given the reality that service users have complex needs. Two referrers spoke very enthusiastically about the creation of 'the NE hub'; a place where they can refer people and a decision is then taken about what service is most appropriate for an individual. One CPN said that she had previously worked with people with drug problems and now works with people with alcohol problems. She saw value in everyone becoming 'addictions workers' in the future, responding to a range of client needs. Two others were adamant that drug and alcohol issues were so different that different services were required.

Service users

Referrers were asked to describe the kind of cases they referred to ART, and those they did not. Most described their referred clients as older, as people who had had alcohol problems for a considerable length of time; many said they were less likely to refer young people who may still be at the stage of occasional 'binge drinking'. Their reason for not referring 'binge drinkers' is because a regular 'pattern of drinking' has not yet developed, and young people probably don't see their drinking as a problem yet (one person said they still think they are Superman!) One social worker referrer said, 'We usually get in touch with ART because someone's drinking is starting to affect other areas of their life like their tenancy and they want to make changes.'

This was an important theme picked up by other referrers. Service users had to want to change for there to be any point in making a referral to ART. One CPN referrer expressed this as follows: 'People may not be in the right place to make changes in their lives, so they don't feel ready to have someone working with them providing a different strategy or

structure – people have to be ready to say 'I want to change something myself – to disengage with a part of myself'.

Given the agency's prioritisation of referrals of people who have caring responsibilities for children, all referrers were asked to comment on this. Surprisingly, all but two said that they couldn't comment on this and no-one could remember referring anyone who had responsibility for their children. A CPN referrer explained that she would tend to see child care and protection work as the task of the community social worker, not ART, although she knew that they did prioritise clients with children, and said she didn't see why they couldn't do more in this area. A social work referrer similarly said that 'if there were any childcare concerns or child protection, they would have to pass that back to the local team. They wouldn't carry child protection cases forward.'

One of the referrers (a CPN) said that she worked a lot with Polish people, and was aware that other support agencies now have Polish staff members. She said that she works predominantly with white service users, as does ART, and she felt that there may be unmet needs, for example amongst the Asian community in Edinburgh. This may require further investigation on the part of ART.

None of the referrers could provide information on what ART was doing to involve its service users in service delivery or improvements. A GP refer said how valuable this was however:

> 'I think service-user or patient involvement is always ultimately likely to be useful. They can provide a different perspective on things, and often have ideas on how to improve things that are simple to implement and therefore a no-brainer. If they offer criticism that can't be so easily fixed, in my view, it's important to know about that, if only so as to consider solutions in the future, or to warn others of the potential weaknesses/pit-falls as identified by the client group with whom they work.'

<u>The nature of ART service delivery</u>

ART, as stated already, is an agency without an office base. It sees its service users in their own homes or other mutually convenient locations (such as cafés) and works with people for a short-term, intensive period of up to 16 weeks. Referrers were asked to give their assessment of the effectiveness firstly, of the location of service delivery, secondly, of the time-limit, and finally of ART social workers' ability to build relationships with service users.

Nine of the 10 referrers saw location as a positive aspect of service delivery. Home-visiting was welcomed because it allowed service users to meet social workers on their own

territory, and also reduced the stigma of having to go out to an alcohol agency. One referrer disagreed, however, suggesting that visiting people in their own homes might increase clients' social isolation.

Referrers expressed mixed views about the 16-week time limit. Some said it was 'about right'; one said that from his experience, 'you can see someone's life is turning around within a month'. There were, however, criticisms of what was perceived as inflexibility in the 16-week service. One referrer said that he thought it was 'absolutely a waste of time'. He said:

> 'You can't do anything with people in 16 weeks. I mean, by 16 weeks you've probably just built up that trust, do you know? For people to, maybe, to open up and say, 'Do you know something? You're alright. I trust you. I can tell you things.' And then, all of a sudden, you turn round and say, 'Oh, by the way, I've just closed your case here. Your time's up.' How is a client going to feel about that? What comes in to that is total rejection. And rejection stuff we come in to that – feeling rejected or, 'Am I not good enough?' So, I would say their biggest downfall is working with clients for the 16 weeks. And whether that's to get targets or whatever, I don't know.'

This referrer went on to describe an occasion when a service user was nine weeks in before he was ready to access ART; he was then re-referred at the end of 16 weeks and went back on the waiting list, ending up with a different social worker. This, he felt, was unacceptable, and he went on to say that 16 weeks was too short anyway to deal with an alcohol problem that a client may have had for 20 or 30 years.

All referrers said that ART social workers built good relationships with their service users. This was seen as a main strength of the service, and was linked to the notion of professionalism. One GP referrer, however, suggested that the time-limit could have an adverse impact on relationships, limiting what was possible to achieve. He said:

> 'I often think the workers build a strong and meaningful relationship which could be reinforced or strengthened by enhanced communication. [...] this is difficult to achieve when time is short, but it's a bit like patients who have strong relationships with their health visitors or district nurses. Linking up the communication and being 'on-message' can often reinforce the relationship for all and enhance the outcomes for the patient.'

This is an important final point, and one that links with the need for good inter-agency communication, for the benefit of all service users.

Work with other agencies

Referrers were invited to outline which other agencies they referred to and why, and how well ART worked with other agencies. This topic produced a range of responses, which undoubtedly said as much about their organisation's success in inter-agency working as that of ART. One referrer (from social work) felt that social work and housing work very well together, but she was less sure about social work and health; she recommended 'one big database' as a way forward. Another referrer, based in health, said that she saw ART as the 'gateway to the Council', and she appreciated this greatly, knowing that when she referred to ART, a patient would be able to access a range of council services.

Another referrer, who works for a voluntary agency, expressed concern about what he identified as the fragmentation of services in Edinburgh. He explained, 'I think we're all double-handling and having to try to hold onto our own bits because of funding pressures. I'd rather see more inter-agency communication and more established parameters – so you can see where one agency begins and another ends. […] We need to be pulling together instead of everyone fighting for their own patch.'

A GP referrer's view of inter-agency working was that it 'could be better'. He suggested that 'multi-disciplinary meetings in practice' would help this, but he acknowledged that these were resource and time-intensive.

Two referrers spoke very positively about the new 'recovery hubs' in SE and NE Edinburgh. These make inter-agency and multi-disciplinary working much easier, allowing for exchange of both views and experience, as one CPN referrer explained:

> '[…] the co-location works well, so does the hot-desking – it's making a real difference. Everybody knows who ART staff are for their area - they are a resource now. They are much more than a service that we refer clients to – we can nip their heads about all sorts – adult protection, benefits issues, changes in community care – that has been a really positive step - they are our link to the world of the council, not just an alcohol service.'

6.2.4 Service users' views

Narratives of service users illustrate the complex nature of their lives, and arising from this, the difficulty of claiming that one particular service or intervention has been effective in its own right. All the service users worked with a number of agencies at the same time; indeed one of the goals of ART is to refer clients on to other resources. As a consequence, it would

be difficult to claim that a service user's 'success' is down to one agency or approach as opposed to another. Some service users' lives were still so out of control that it would have been difficult to say that anything had worked. This theme emerged in many of the interviews. Most service users were still drinking alcohol (only one claimed to be totally abstinent), although most said they were avoiding spirits, and drinking less to excess. Their lives were undoubtedly better, but they had some way to go towards anything that might be viewed as full recovery.

Nature of ART service delivery

Service users were all invited to comment on three specific areas in relation to ART's effectiveness: the office-less style of delivery, the 16 week contract with service users, and the relationships they had with the social workers.

All of the service users agreed that having the flexibility to visit them at home or meet in a café was welcomed. G (aged 49) spoke for many when he said: 'I didn't want to leave the house, I didn't want to bump into anyone that I know, and actually, I was having physical problems with my balance and walking…' H (aged 45) agreed that home visits were helpful because he had 'good and bad days' with his breathing that made it difficult for him to go out sometimes. J (aged 34) meanwhile appreciated that the social worker had met him in a coffee shop when he was homeless.

Service users had mixed views about whether or not the 16 week contract had been enough for them. Those who had had a specific piece of intervention in mind felt that it was long enough. For example, G had wanted help with making a DLA application, and this was achieved. Others said that 16 weeks was far too short a time to 'turn your life around', especially when problems may have been ongoing for twenty years or more. J put this as follows: 'The way my life's been recently it should be longer, I think, because there's a lot to deal with, sort out. […] Things got worse after my time ran out.'

What else was going on in a service user's life at the time of referral to ART undoubtedly had an impact on their capacity to make use of the help and opportunities offered. For example, E (aged 43) said that his daily life was too disrupted by illness and hospital appointments to give him space to engage with the voluntary activities and computer classes that were recommended to him. He was grateful that the ART worker had 'tried his best', but, as he explained, 'it wasn't feasible at that time'. Another service user, I (aged 50), advised that 'you don't get the benefit from ART until such times as you've actually detoxed and maintained sobriety for a short period'. He wasn't ready at the start of the referral (he was still drinking

heavily) and therefore lost time on the 16 week period, although again he welcomed the help he did receive from ART.

All but one of the informants expressed praise for their ART social workers, whom they saw as committed and knowledgeable people. Perhaps not surprisingly, service users found it easier to talk about their individual social worker than about the agency; for them their worker *was* ART. One female service user (aged 28) whose children were being looked after said that she was 'not getting on with social work at the moment', so the ART worker had been especially important because 'it gives me someone else to talk to and new ways of thinking'. This reflects something that comes through almost all the interviews. The ART social worker was not seen as a 'push over', as someone who was afraid to confront difficult realities. Forty-year old C (a woman) expressed this as follows, saying: 'We just clicked like that. She wasn't judgemental, which was a good thing, but she put me in my place when she thought I was out my place. She just grew to be sort of a friend'.

Work with other agencies

The agencies whom service users spoke of were APS, NEDAC, Turning Point, the Cyrenians, ELCA, LEAP, the Andrew Duncan Clinic, Simpson House, Neighbourhood Support Team, as well as local authority social workers and GPs. There were also a number of places where service users were taken and they said that they didn't remember the agency's name ('a service off the Royal Mile that helps you to come off the drink', was one example).

6.2.5 Conclusion

Whilst it is demonstrably difficult to measure effectiveness in such a difficult and ever-changing landscape, nevertheless, when it comes to real people's narratives, we can see real desire to change on the part of service users, and an acknowledgement that ART social workers have been a key part of this, not least because of the relationships that they were able to build. It is also evident that referrers, on the whole, think that ART is providing a professional, expert and useful service to a range of troubled and troubling clients. It has been acknowledged that it is impossible to measure 'high level' or even 'intermediate level' outcomes in 16 weeks, but this tells us something about the recovery journey – it is a process, and what we have seen mostly in the findings is the small steps taken along the way. The importance of good communication has been stressed, between staff and service users but also between agencies and professionals.

A number of suggestions emerge for improvement. These include better record-keeping systems, and a clearer statement about both their ethos and what can and cannot be achieved in the 16 week time-frame. Referrers would like more feedback about how clients and patients they refer fare; although ART staff advised us that this should always take place, by phone or letter, this is clearly either not the case at present, or that the information sent back is not reaching the person who made the referral. More generally, this suggests the need for more and better inter-agency working, as is being demonstrated in the new 'recovery hubs' in Edinburgh. Good communication is clearly vital, because with so many people and agencies involved, the possibility of overlap is evident. It is also possible that one worker may think that something is being done and it isn't, hence the need for good inter-agency cooperation.

There has been a suggestion that ART and DRT might be merged to become one service. We did not ask this question directly, but it nevertheless came up in discussion, and seems likely to be an issue that the City of Edinburgh Council will wish to consider in the future. If this seems likely, it needs to be remembered that the ART and DRT service user groups are different (as we will see) and their needs may also be different.

Finally, the question of ART's response to the BME community has been highlighted, although it is acknowledged that firstly, that ART now has a BME worker and secondly, that the issue of how to work better with BME communities is one that is shared by all Council services in Edinburgh. It is suggested that further discussion may need to take place with community groups in order to take this forward.

7 Findings: DRT

As in the ART evaluation, the DRT evaluation interrogated both what was achieved (i.e. outputs) and how well it was achieved (i.e. effectiveness).

7.1 Evaluating outputs

Outputs were examined on two levels: at services level and as experienced by service users themselves. The relation between identified and actual output was also analysed.

7.1.1 Services-Level Outputs

What was the service expected to accomplish?

DRT's documentation states that it is a city-wide outreach service within The City of Edinburgh Council and an adult social care service within the City of Edinburgh Council's Department of Health and Social Care. DRT's foremost task is said to be to reduce drug related harm for service users, their children and their families. It describes itself as a social work service specifically for service users with a problematic relationship with drugs who also have multiple and complex needs that provides short term (16 weeks) focused work. Each service user should receive a full Community Care Assessment and Case Management Service, with a written Action/Care Plan. DRT is a service based in service users' own homes (subject to a risk assessment), although both the Service User and the Social Worker have the option to negotiate meeting in another suitable venue. During the assessment process, DRT is expected to develop a Recovery-focused holistic Action Plan focusing on the service user's understanding of their needs and their aspirations; it may also include housing, employment, benefits, parenting supports etc. DRT states that it will refer the service user on to the services most appropriate to meet their individual needs; these services will not necessarily be drug-focused and offer to escort the service user to first appointments to ensure engagement with the services agreed in the Action Plan. DRT aims to actively continue to support the service user to redefine their needs and expectations of services throughout the 16 week period. Three months after case closure the DRT Team Leader should appoint a member of the substance misuse services to contact the service user to get feedback on the service that DRT provided and whether the Action Plan is still operational. Re-referral to DRT is said to be a possibility if the action plan has broken down. DRT should hold annual Team Away Days to promote team building and operating effectiveness. The introduction to the service's operating instructions concludes: 'DRT is

committed to the development of the Recovery pathway for service users; this entails joint working with NHS Lothian and 3rd Sector partners. The social work service will change and develop in line with the service reconfigurations developed by the Edinburgh Alcohol and Drug Partnership.' The specific outcomes measures that it is working towards are as follows:

DRT	Outcome measures
Substance Misuse Behaviour	Reduced use of (illicit) drugs
Physical and Psychological Health	Improved psychological health
Social Functioning and Life Context	Reduced chaos in daily living
Personal Development	Increased self-worth
Family/Parenting	Children are safer
Service Outcomes	Increased access to a wide range or treatment and other therapeutic interventions

Figure 10: DRT Outcome Measures

To what extent has this been achieved?

As in the ART study, two sources of evidence were examined: all 'cases' from 2011 drawn from SWIFT reports provided by administrative staff in DRT and a subset of 50 of these.

Analysis of all 2011 cases

Agency records tell us that 240 referrals were received in 2011; 15 of these were re-referrals and 225 were new referrals. Fifty-nine per cent (n=142) were male and 39% (n=94) female; in three instances gender was not recorded and in one case this was not disclosed. More than two-thirds (68%) of service users were under 40 years of age as outlined the figure below. This differs from ART, which was found to have a much older cohort.

Age	No. of referrals
16-20 years	2% (n=5)
21-30 years	23% (n=56)
31-40 years	43% (n=104)
41-50 years	23% (n=55)
51-60 years	7% (n=16)
Over 60 years	1% (n=2)
Total	**100% (n=240)**

Figure 11: Referrals to DRT in 2011

Most service users were recorded as white; two were recorded as Arab; two as mixed; one as Pakistani; six refused to give their ethnicity; three were not recorded and in 45 cases, no 'race' or ethnicity was recorded. In line with ART, the number of referrals of black and ethnic minority (BME) service users is low. Significantly, there were no African or Caribbean referrals and a high rate of non-recording of ethnicity. A consultation on substance use and addictions in BME communities carried out between 2005 and 2006 highlighted the ambivalence of BME people to access mainstream and BME oriented services (EMEDI, 2006). This was coupled with a stated concern amongst BME community members consulted about drug use and a desire for information. The report recommended that mainstream organisations should become more accessible to members of these communities.

A majority of referrals came from health sources such as community health and GPs (68%). Local authority agencies accounted for 19% and 9% came from voluntary sector sources. This is reflected in narratives from DRT staff members, suggesting closer relationships with health colleagues than with local authority Social Work/community care teams.

Reasons for ending are detailed in agency records. Contact was ended with 214 service users. Only 36% (n=72) of cases were recorded as 'work complete' (see figure below). A quarter of endings were recorded as 'lost contact' and 'not recorded' – a total of 55 cases.

End Reason	**No. of Closures**
Closed at Service Users' Request	22
Inappropriate Referral	8
Lost Contact With Service User	46
Not Recorded	9
Service No Longer Required	43
Service User Deceased	1
Service User Moved Out Of Area	4
Transfer To Another CEC Team	5
Work Complete	76
Total	**214**

Figure 12 : Reasons for Ending (DRT)

A number of observations can be made about this information, again in common with the issues already raised in the ART discussion. Firstly, the high number of 'not recorded' and 'lost contact' raises questions about why these clients have potentially disengaged. Secondly, what should we infer from the 43 recorded as 'service no longer required'? Were these agency successes or not? It is impossible to tell from the current recording systems. And why are 10% (22) 'closed at service user's request'? Again, does this infer the service was no longer required, and if so, why is this a separate category? It is clear that for this information to be useful to the agency, the 'Reason for Ending' record needs to be amended so that it is more fit-for-purpose.

Analysis of 50 cases

We analysed 50 service reports in greater detail, drawing on referral forms, care/action plans, case-notes and post-closure returns and building analytical themes from this. This process was not straightforward. Records were incomplete: although reports provided extensive information about identified needs, they did not always explicitly record planned actions and outcomes. Of the 50 cases analysed in detail, only 14 gave clearly recorded outcomes. (See further discussion of data collection in section 5 on Research Methodology.)

	Support needed	**Support provided**
Problem/concern	Citations	Citations
Addiction Problems	59	12
Adult Protection	2	2
Child protection concerns	12	4
Family problems	12	0
Financial problems	22	14
Housing problems	23	6
Legal problems	5	0
Mental health/well-being	43	10
Offence related problems	14	4
Physical health / disability	26	25
Social	32	29

Figure 13 Support Needed and Provided - 50 cases from 2011 (DRT)

Notes:

- In all situations, more than one support-need was identified; hence the total number of citations is greater than 50.
- 'Addiction problems' covers a range of identified needs, including alcohol; drugs, and detox and rehab.
- Housing problems includes help required with homelessness and tenancy support.
- Most citations in the mental health/ well-being category were listed as 'mental health' but this broad category includes 'cognitive impairment', 'bereavement', 'anger issues', emotional problems' and 'sexual abuse/ rape'.
- Physical health/disability includes HepC and HIV.
- Social problems are taken to cover education, general/life skills; and 'social needs'.

A number of observations arise from this. Just as with ART data, it was difficult to categorise either the support needed or the support provided, because the agency uses different terms for similar things and the data are recorded differently by different people. There are also many gaps in the records, so it is impossible to be certain in many of the situations that 'x' service user had 'y' needs and that these were met in 'z' ways. This is, of course, the nature of addictions' services: clients never simply have one problem (as our figure suggests), and many service users disappear before the end of programmes (some do not engage, and many drop off along the way). Hence, there are inherent problems in data collection and analysis for this group of service users. It also, however, suggests that more could be done to standardise recording (social workers are currently using multiple electronic systems and forms for recording outcomes).

Setting to one side the technical flaws in the data, important findings emerge. Firstly, as with ART clients, drug problems were accompanied by a range of other problems (including, for a significant number, problems with alcohol). Secondly, concerns around mental health and well-being were particularly high, mirroring evidence from wider research about the strong connection between substance misuse and mental distress (see Galvani, 2012). Issues around housing/tenancy/homelessness were common, as were social needs, from a variety of aspects, again illustrating the disruption that drug misuse can bring to lives.

A closer analysis of cases representing service users who fully engaged with the programme provides further illumination (see figure below). In this cohort of 50, 21 completed the 16-week programme and 58% of cited needs were reported to have been addressed. Within

this cohort of 21, there were 21 citations of physical health problems and 28 citations of mental health problems. There were 13 citations of support provided for physical health and eight for mental health. This may suggest that given high referrals from health services, clients did not need direct assistance with these issues. This may also reflect the lack of services, however, particularly for those with mental health problems. In contrast, financial issues were well-addressed with 17 citations of need and 13 citations of support provided. Housing, likewise, had 16 citations of support needed and provided. Child protection concerns were also said to have been met, as were legal problems. Within the broad category of social problems, education and life-skills also tended to be provided satisfactorily.

	Support Needed	**Support Provided**
Problem/concern	**Citations**	**Citations**
Drug misuse	26	17
Alcohol-related problems	1	0
Child protection concerns	6	4
Family problems	6	1
Financial problems	17	13
Housing problems	16	16
Legal problems	3	4
Mental health/well-being	28	8
Offense related problems	7	2
Physical health / disability	21	13
Adult Protection	1	0
Social	23	13
Total	**155**	**91**

Figure 14: Support Needed and Provided to those Fully Engaged - 21 cases from 2011 (DRT)

7.1 2 Service User-level outputs

Interviews with service users demonstrated that clients had a range of objectives and expectations of what might be achieved by working with DRT. They were also clear on the outputs of the intervention. A total of 10 service users were interviewed, seven males and three females; nine were white and one a BME person.

What was the service expected to accomplish?

Drug problems

All but two of the 10 interviewees identified drug usage as a problem which they wished to address through involvement with DRT. Two informants, who did not identify drug usage, discussed related issues of social isolation, support and housing. For the other eight informants, expectations of assistance with drug usage were clearly linked to other life problems. For example, K (male, aged 37) saw reducing cannabis usage as central to addressing other problems such as anxiety and depression. All 10 informants had in the past or were currently involved with workers whose main task was to work with them on drug issues. These workers came from agencies such as CPDS, LEAP, Crew, SACRO, Streetwork, Narcotics Anonymous, Simpson House, ELCA, Turning Point, and MELD.

Health problems

Most informants described having mental health problems included long-standing depression, anxiety, trauma (one instance), schizophrenia (one person) as well as histories of attempted suicide and self-harming. Physical health problems were less commonly mentioned and included one person with Hepatitis C and another person with multiple chronic ailments. Informants did not identify health problems as something they wanted DRT to address. However, they did in some cases link help with other problems to reduction of mental health problems.

Housing problems

This was a common problem for DRT service users interviewed. Housing needs revolved around housing transitions (i.e. arranging hostels or council accommodation) as well in one case arranging disability-related adjustments (MH), and improvement of housing conditions (e.g. providing white goods). Most informants identified improved housing conditions as an important step to changing their lives.

Financial problems

About half of the informants required help with income and financial issues. These impacted on other aspects of their lives, particularly housing and drug use. These needs primarily related to accessing welfare entitlements, specifically help in navigating the welfare bureaucracy and forms. In one case, a female informant (L aged 44) required help with issues of financial literacy.

Issues around access to children

This was an important part of service users' narratives. Two of the three women who were interviewed had children: one had a child currently looked after and accommodated and the other had children who had been adopted some time ago. For this informant, making contact with her children through learning to read and write was an expectation she had of DRT involvement. Five of the eight male informants had children for whom they had no day-to-day caring responsibilities. However, two of the men sought to reduce their drug use as a means to allowing them to resume relationships with these children in the future.

Low self-esteem and social isolation

This was experienced by almost all service users in different ways. For many of the informants, drug usage and related mental health problems had left them isolated from friends, partners and children. This had impacted on their sense of self and confidence.

To what extent has this been achieved?

Nine out of 10 of the service users interviewed were satisfied with outcomes of the DRT interventions. The dominant experience had been positive and informants were grateful for DRT involvement. The single informant who was not satisfied felt that DRT had helped her with accessing help to obtain a divorce and linking her with an adoption agency to locate her children. However, she felt that her worker had done little to assist with her drug problem. She stated that the worker should have played a more pro-active role by taking her into agencies she had been referred to. She also thought that her worker was inexperienced.

Drug problems

Most informants had or were receiving support from other workers or agencies for their drug problems. DRT played a central role through referral to other drug services. However, the main role of DRT in relation to drug problems was by providing a highly accessible and intensive support service that engaged with service users on a range of issues related to drug use. K stated: '…it's motivationally supported and she gave me more things to think about that I could maybe be doing for myself, other angles that maybe my counsellor and other people hadn't looked at….'.

Health problems

DRT made referrals to a range of health agencies, most frequently for psycho-social support. Social workers also spent considerable amounts of time listening to service users. A service user described his DRT workers listening skills: 'She was like - even if I'm meeting her after five minutes, it was like I knew her for quite a while, so she made you feel at ease. She was very comforting, easy listening - and that is one of the main things. She'd sit and listen to you. If I was in a bad mood, she'd just let me go on and on for ages and she'd just sit and take it, I think.' This support and listening had important mental health outcomes for example by reducing isolation. One service user (M aged 38) stated that his DRT worker '…stopped me from killing myself'.

Financial problems

Service provided in this area was primarily around direct assistance with form-filling and engagement with welfare bureaucracies including explaining systems to service users and making phone calls. This was an important source of help playing a central role in shaping other aspects of life. A female informant (L) stated that help with finances was crucial to drug misuse.

Housing

DRT supported service users with a range of housing issues. This included assistance in applying for a tenancy, referral to housing specialist agencies, arranging for disability related housing adaptation, and assistance in applying for funding to improve housing.

Issues around access to children

From the interviews it was difficult to assess the extent to which this was achieved.

Low self-esteem and social isolation

DRT workers played a central role in reducing isolation and helping service users to improve self-esteem. This was through a combination of the relationship that workers could engender with service users and the nature of the help they were able to provide. Asked about the most helpful part of the service, one service user (L) stated: 'I think most of all it's like she is, kind of, make me understand that she can be always by my side. All I need is just text her a message. Text her and she's going to always get back to me. You know, it's like a kind of a… I feel relieved because it's, kind of, mental support, kind of, emotional support.'

Another service user (P, age 43, male) discussed how DRT support boosted his self-esteem:

> 'I think she's given me a wee boost saying that I was articulate. You have to hear somebody saying it. If somebody really close to you says it, you think, okay, he'll be after a fiver or something, but when you hear somebody that's...and I know [social worker] has been in the drug rehabilitation project for a while with being in the Links Project, she obviously knows what she's talking about. I didn't think I was inarticulate, like. She said I was articulate.'

7.1.3 Conclusion

Service users are mainly under the age of 40 years; this is quite a different profile to the ART service users. However, in common with ART, there were very few BME service users. A majority of referrals come from health sources. The evidence suggests (again as with ART) that the agency does address a range of issues and provides support in referral, advocacy, emotional and social support and information and advice. A high number of needs were addressed by those who completed the programme, focusing on housing, finance and social support, including education. A high percentage of service users had physical and mental health problems. The lack of services to which DRT social workers could refer those with mental health problems was highlighted in the evaluation.

7.2 Evaluating effectiveness

As in relation to ART services, making an assessment about whether or not a service is effective demands a clear statement about how effectiveness is being measured and by whom.

The Ministerial foreword to the Scottish Government's flagship report, *The Road to Recovery* (Scottish Government 2008) states that it sets out a 'new vision where all our drug treatment and rehabilitation services are based on the principle of recovery. This commitment to recovery, to responding to the desire of people who use drugs to become drug free, lies at the heart of this strategy.' The foreword continues: 'Aiming for recovery means coupling common sense with aspiration, and pragmatism with idealism. It means that public money invested in drug treatment services should have clear outcomes attached to them. And it means that we must treat each person using drugs on their own terms, and centre care around the person, not the addiction. At the same time, we need to make sure that, right

across Government and public services in Scotland we are doing what we can to prevent drug use in the longer term.'

As in the ART evaluation, we have looked at two sources of evidence for effectiveness. The first was a detailed analysis of service user evaluations selected at random. These are the evaluation questionnaires that are administered three months post-closure asking about levels of satisfaction with the service received, views about staff and relationships and about any improvements in their quality of life. In DRT, evaluation questionnaires are administered by a social worker over the phone. The evaluations provided both quantitative and qualitative evidence. The second source of information was interviews conducted with staff, referrers and service users.

7.2.1 Service user evaluations administered by DRT

Service user evaluations for DRT are administered by a social worker on the telephone, using a comprehensive form (one that asks many more questions than the ART evaluation). Out of the sample of 50 cases, only three service users completed post-closure evaluation questionnaires. These three were set aside and 10 additional questionnaires were randomly selected from the full 2011 cohort of cases.

Services accessed

The DRT evaluation asked service users to 'list the services/resources the DRT social worker helped you to access, or tasks he/she helped you complete'. Service users received help with filling in forms (10), accompanying to appointments (8), housing (7), budgeting (4), and advocacy (9). All service users accessed some kind of external service. Each mentioned between one and four services that they had accessed with DRT assistance. These included services in the following sectors: education and training, substance misuse, charities (such as Bike Station), home visiting support, and volunteering. The impact of this is illustrated in the words of one service user:

> '[DRT social worker] got me to the dentist and the podiatrist. My teeth and my feet were in a shocking state. Teeth were black and sore and I never smiled and I could hardly walk with my feet. For years I'd not done anything about these things. But [she] came and got me to the appointments and now I can walk everywhere and I smile at everybody'.

Seven out of ten reported that they still used some of the services they had accessed through DRT while eight stated they would not have accessed these services without DRT's help.

Are service users better off after DRT intervention? What proportion of service users are found to be maintaining recovery at post-closure stage?

The DRT evaluation provides some answers to these two questions. Question three of the evaluation asks about the impact of DRT involvement on drug usage through quantitative questions and narrative responses. Service users are asked to provide a yes, no or not applicable answer to eight questions:

- Prescription reduced?
- Stabilisation achieved?
- Prescription increased?
- Prescription unchanged?
- Illicit drug use, e.g. 'topping-up' ceased?
- Illicit use reduced?
- Illicit use unchanged?
- Illicit use increased?

The framing of these questions has led to contradictory results. In our sample of ten service users, five stated their prescription was reduced, three stated it was not, and two marked this as non-applicable. However, in a separate question ('prescription increased?), four stated that this was not applicable; five stated it was not increased, and one stated it was increased. There were similar discrepancies in other questions. Despite these issues, we can draw some useful summary information:

- About half of service users reported a decrease in their prescriptions.
- Just under half (4) reported achieving stabilisation.
- Illicit drug use was reported as having ceased for all those for whom this was an applicable problem (3)

Narrative comments provide a picture of the progress made by this group of ten service users:

> 'My stability with drugs was fine, but I really wanted to start reducing my Diazepam, been on it for 18 years, and since things have been so much better I've managed to reduce by one yellow a day. That's been even though I had a still-born son, which knocked me back a bit...'
>
> 'I got so many clean toxicologies (sic) that my GP was able to take over my script.'

‘I was and am still on a 30mg (methadone) prescription, I have never topped up.'

‘I remained stable in my prescription and never topped up.'

‘I used to buy extra Valium to top up but I stopped doing that.'

‘When I came out of the Ritson my flat wasn't finished like my son promised so it caused me to have a wee relapse so I'm going back into the Ritson.'

Both narrative and quantitative data suggest some service users are better off after DRT intervention. Though this data must be read with caution given it is self-reported and the contradictory responses that the questions generated.

Question four of the evaluation asks service users to rate ‘big changes’ across a number of domains that happened as a result of DRT involvement using categories of ‘better’, ‘worse’, ‘no change’ and ‘n/a’. These results indicate that some service users were better in every area. All ten clients reported better physical health, nine reported better mental health, and six reported better housing. One client reported worse mental health.

Question five discusses goals and obstacles. All ten clients reported being significantly or somewhat closer to achieving their goals. One client stated: ‘I haven't got to college yet but hope to by summer 2012. I have also bought weights so I can get fit at home. Still waiting on housing though. I am still using cannabis, but am trying to get this down. I am hoping to be on Subutex soon.'

Question six (a) asks ‘Has your motivation to make life changes altered since DRT involvement?’. Three respondents answered ‘significantly’, six stated ‘somewhat’ and one reported ‘no change’. Question six (b) asks about changes in quality of life. Four said this had changed significantly and six said somewhat.

<u>What impact do ART and DRT services have on others in the family of the user, especially on children?</u>

In question four, eight service users reported better relationships with professionals, six reported better relationships with family/friends, and four reported better ‘social involvement/general/community’. Five reported better parenting and one reported worse parenting. Those having involvement with children were reported better outcomes: two said they had better status with children and families social work (eight – non applicable) and three reported better contact with children (seven – not applicable).

Narrative comments support these findings of positive impacts on families and children. One person said, 'We're all doing really well. Planning a weekend away in September, first one in years! Doing things like ice-skating, all sorts of stuff.' Another said, 'I have on-going back problems from when a car hit me but everything else is good. I smile in public, I go out all the time. Getting out with [DRT SW] gave me some perspective on things, on the size of Edinburgh. Now I see my son - he lives across town - every week. He's 4 years old, and before [DRT SW] came along I was never seeing him. Now it's every week. A boy needs his dad...'

What did service users feel about the value and quality of the service they had received?

Section seven asks service users to describe the DRT worker's attitude an approach to their needs. The sample of ten evaluations provided rich and positive comments highlighting the individualized and dependable nature of DRT services:

> 'Nobody's perfect but [DRT SW] was 99.9% there. She was good at reading me, not letting me get distracted, she would pull me back to focus and what we had to do [sic]. You could set your watch by her. She was there for me. It was reassuring that things were going to happen. She was only ever a text away.'
>
> '[DRT SW] slightly raised my self-confidence, and was definitely respectful, I found it hard to put my trust in people but I could with [him].'
>
> '[DRT SW] treated me in the same way I treated him, if I gave him respect he would do the same. [He] was a challenged for me, but working with him, helped me communicate with men the same age as me, which I haven't been able to do before.'

7.2.2 Staff views

We conducted a single focus group with DRT staff team (excluding the team leader and senior social worker) and individual interviews with the DRT team leader and senior social worker.

DRT's ethos and services

A central theme emerging suggests that the holistic nature of the service was central to its effectiveness. The idea of a holistic service reflected a number of different principles. Most importantly, the service was seen as client centred. One Social Worker said: 'It's more client, as … says, more holistic but also the client is repeatedly given the message that they are in charge, they have more control they have more, it's more alongside the client…'

A senior manager stated that this was about partnership working with a client and moving away from an expert-dominated agenda. Such a holistic approach necessitated that the client define their own problems.

A holistic approach also linked directly to the role of social work which was seen as central by all informants. Social Work was seen as providing the lens through which to understand all aspects of a person's life. The senior social worker said:

> '..we do a full comprehensive social work assessment, which looks at every single area of the person's life. It's not just about their drug use, and it's not just about, you know, there are other problems. It's about all the things together. You know, we look at the whole thing, the whole package, the drug problem, the mental health problem, the housing problem, whatever all the problems are, we look at them all holistically, and we work with them towards resolving all the problems, all the areas of their life, and refer them to the appropriate services, and put in that package of care and support. Whereas I feel other services are, kind of, for one bit or another bit, you know, not for the whole thing, the whole package, all the needs together.'

Thus, a holistic approach was seen as imperative to the effectiveness of the service.

<u>Recovery</u>

DRT staff believed that recovery should be defined by the service user. As one social worker stated:

> 'I think you have to say what works for whom and what contacts. People are, it's not a homogenous client group, so you have to take a kind of realistic approach to that and it's very different, but I think despite whatever the current policy is, we have to take a person focused approach and we have to go with their definition of recovery.' (F3)

The team leader comments on her view of recovery:

> '..where I would start and where I am sure all the team would start is with the person, how they would see their recovery and I would move away from using as much jargon as possible because I think even the word recovery now has so many definitions and there's been some dispute that you'll know about..'

She went on to state that DRT see recovery as a spectrum and not as an end result. This was amplified by an example described by a social worker:

> 'It [recovery] varies, I think it varies so much, I've had somebody go from hell to university in the time I've had to work with them, but increasingly I think with or complex needs focus which has now been kind of specified, it maybe always did, but we now specifically work, we are doing a lot more keeping people alive, you know, getting people into university and complex multiple health issues, complex housing issues, things like that which need to be addressed before people can begin to look at changing their drug use at all. So a lot of it is the underlying work that will enable recovery at some point.'

The value of a social work perspective was seen as important to recovery as many of the issues linked to recovery might go beyond drug issues to encompass wider problems in client's lives. The team leader stated that 'skilled engagement' by DRT staff with service users supports recovery:

> '…it's really important on first meeting to engage with the person, and to demonstrate respect, not just pay lip service to it and to use all the listening skills or communication skills needed to get a dialogue going and within that dialogue allowing the person to define their own self, a sense of narrative, and rounding it off really with moving on, how they would like to move on and how they would...how they would identify their own core problems and what given those problems did they feel they need assistance with. And we might offer them some examples, such as do they feel they need to direct support with housing, welfare rights, benefits, debts, which are often key factors and which are often if you don't kind of recognise that working on those, not to work on those would mean that the person's gonna struggle to move on with other things.'

She went on to discuss the relationship between an engaging relationship and providing practical support such as accompanying a person to an appointment:

> '…we had somebody only yesterday saying it's having a name in a phone that you can call and check things out with that has aided recovery because it's been two-fold, that there's been a feeling of somebody there holding you in the process, but there's also been the practical stuff that we've several times for feedback that people have moved further towards recovery, they have done so because it's not just a talking shop as they might see it, but there's practical things that can be done with them and sometimes more.'

The team leader noted that recovery could be evaluated in 'real' terms by considering both small and major achievements in people's life circumstances as well as reduction in drug usage.

Complex needs

We sought to ask DRT staff about their views of how effective they were in addressing complex needs. Social workers described the difficulty of working with complex needs within a 16-week time frame:

> 'We often do have to do more than one piece of work, particularly people with complex needs because you can get less done, you've got 16 weeks, you're dealing with, I have a case at the moment where the guy was referred by CDPS, who is the psychiatric nurses from substance misuse service, and the guy has an acquired brain injury and there are huge carer issues, they will need to be carer assessments, there will need to be OT assessments, there will need to be homecare assessments, I've referred to a complex need housing support agency. You will be looking at about 10 to 15 hours of support a week; he is on the waiting list.' (F3)

This worker felt DRT would be more effective if they could work long term. He went on to describe how partnership working and DRT's position in the local authority allowed them to address a full range of needs by coordinating with other agencies. Another Social Worker argued that the skill to effectively coordinate responses to complex needs was essential to DRT's role:

> 'The key thing is just now probably we would only do the work with people with multiple complex needs, as soon as we respond to it and also the fact that we (with being a resource team) it is incumbent on us as workers, to be aware of the full range of services that are potentially, and are simply not found in different services, the responses were limited in experience. It's like the core of our job to think as globally as possible in terms of what the correct intervention might be or the correct source of support.'

Attending to complex needs often required creative response that DRT with their social work role was able to achieve. Workers described example of role boundaries between agencies might leave a client stranded. Here DRT played an important role in coordinating and filling gaps that other agencies couldn't cover due to limited mandates. This could require a DRT worker to enable agencies with different remits to come together to support a client's needs.

The team leader stated that a comprehensive assessment including a home visit was essential to understanding complex needs. An important aspect of addressing complex needs was advocacy with different care providers to ensure a client's needs were met.

Support and Training

Social workers were asked about the relevance and quality of the support and training they received. On the whole staff felt that they were encouraged to obtain training relevant to their role. In addition they felt that there was a strong support within the team on areas of expertise that particular members might hold. One worker expressed concerns that they might receive additional training on issues of drugs to improve knowledge in this area. Others felt that due to their generalist training and work, it would be difficult to know the drug field in great detail. And rather they should rely on specialist colleagues in other services for advice.

Social workers felt they received adequate support at the team level. However there was concern expressed that senior management at City of Edinburgh level did not always value or recognise the team's role and contributions. For example, one social worker stated:

> I think senior management not recognising our existence or it almost feels like sometimes you can get a bit paranoid and think that you want to be marginalised along with your clients.

This also related to relationships with Health and other Social Work functions of the Council discussed below.

The nature of DRT service delivery

Staff were asked their views about the approach to service deliver at DRT. A major theme of discussion that emerged was around the 16-week time limit for working with clients. According to the team leader, this is an issue that is constantly debated on the team:

> 'However we do continually debate this and what we're seeing is that as part of people's recovery it's not a linear process, we recognise that people will do a certain amount of their recovery plan and maybe have some setbacks and life comes along in the middle and it can set them back, but they can and do get referred to the team again […] people will come in and they will find a way to complete recovery and I'm worried that that bit is not being given enough recognition, that we're not wasting our time here when people have a lapse or a relapse or get back on the board with them and we will say to them, well what's changed, because there's usually some change, it's just that it's difficult to make big changes.'

The 16-week time limited raised practical challenges for social worker especially given that they were often dependent on other services to put supports in place. This is amplified in a period of service cuts and waiting lists. One worker stated that this impedes recovery as just when a client is moving on to the next phase of their recovery, it is time to close the case. As one worker stated:

> 'That's a conflict area because you're holding this case which is increasingly complex, you're under pressure to close it, but the services that you need are not in place yet, and I don't basically close cases at that point, because I've never been…
> […] you've got 16 weeks here, in other words it's over the limit and what are you doing about it and when are you closing it and you're still waiting for the visiting support.'

There were differing views within the team about the type of pressure that social workers faced to meet the 16 week targets. Some felt they were under tremendous pressure while others felt there was flexibility in the system. Social workers also said that although the evidence-base supported 16 weeks of work with substance users (alluding to brief intervention research here), the nature of services had changed and it wasn't possible to access services quickly. One worker felt that this diminishes the client-centred nature of the service:

> 'That's where it stops being client orientated, you go to meetings, you go to children panels or like reviews and stuff, and there is a lot of dates set for something, there is another piece of work that needs to be done very much around the parent and I have to say, well I have to close this next week, and they look horrified, they are why would you close this just when this is happening or just when that's happening, and sometimes I have to come back and argue the toss with the boss, to see if I can stick it for another few weeks until that next hearing or that psychiatric assessment or that service is in place, or the child comes home and there is going to be an unstable period there needs to be additional monitoring, that is a constant juggle.'

A senior social worker stated that they do have flexibility with 16 weeks, and are able to hold a case open until supports are in place. However, increasingly they are under pressure from 'HEAT' targets. (NHS Scotland set HEAT targets for a range of services, defined as: Health Improvement for the people of Scotland - improving life expectancy and healthy life expectancy; Efficiency and Governance Improvements - continually improve the efficiency and effectiveness of the NHS; Access to Services - recognising patients' need for quicker

and easier use of NHS services; and Treatment Appropriate to Individuals - ensure patients receive high quality services that meet their needs.)
See
www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance

Work with other agencies

Staff were asked about their relationships with other agencies. A dominant view was that these relationships were instrumental to their work. However, staff expressed concerns that the team was marginal in relation to both, having to fight for legitimacy with Health and for 'Social Work' space with more dominant streams such Children and Families and Community Care. This was reflected in the low number of referrals they received from Community Care Social Work.

There was also a view that as a Team they had to constantly define what they do given that do not fit as a conventional drug service. One Social Worker stated:

> 'And a constant need to define ourselves and redefine ourselves and define ourselves against everybody else, how are we not the same as the drugs agencies, how are we not the same as health, how are we not the same as children and families and community care, so I think there is a constant need for us to think about who we are and what we're doing and how we fit.'

Staff felt improving relationships was a constant challenge. This related to the changing service landscape with increasing competition but also to the fact that relationships were based on personal connections with particular workers. One worker stated:

> '…if faces change we have to keep going out and reminding them, this is who we are this is what we do and it's through those personal partnerships of team work around the client, around the family, that those relationships are built up and some of the prejudices and misunderstandings can be chipped away at again, but it's an on-going thing you have to keep at it.'

Another social worker described this as their 'community development' role:

> '…going out and actively engaging, meeting people in the communities, meeting with the agencies, particularly the grass roots agencies and, you know, introducing yourself and finding out what they do, and forming networks with them, because that is going to benefit the clients. It is also going to benefit you as a worker and if it's a support network for you as well.'

The team leader's interview supported this. She stated that engagement with other agencies has been central to DRT's work since its inception.

7.2.3 Referrers' views

The ten referrers interviewed were generally very positive about DRT's service. They felt that DRT provided a level of support and engagement that is unique within the mix of drug services in the city. DRT workers were viewed as well-trained and professional in their approach.

DRT's ethos and services

Interviewees identified a number of aspects of DRT's ethos though a minority found this question difficult to answer. Answers focussed both on the nature of the service and the specifics of how DRT worked. Informants described DRT as 'holistic', 'person-centred' and 'empathic'. One informant a CPN stated:

> '…they provide a holistic service for complex or complicated drug users, looking at case management after a full assessment of their needs.'

Another referrer stated:

> 'They very much look at the whole person and see what they feel the whole person could benefit from.'

This was further specified by other informants with descriptions of DRT as an 'outreach service' and as a service that knew about community resources. DRT workers were seen as committed to service users and willing to work to help SUs achieve their goals.

Recovery

Respondents were asked to comment on DRT's effectiveness in supporting individuals towards recovery. Responses on this issue were largely positive. One addictions' worker from a voluntary agency made a comment typical of six informants: 'Extremely effective. Very happy with them'. Another informant stated:

> 'Very effective because they can give a one-to-one much more intense service than we can. If I'm right, they still have a 16-week...they will see and support people up to 16 weeks. But they will go to do home visits, and they will accompany people to their medicals at York Place. They will accompany people to the housing, so they can be there to advocate for them and to help them with discussions. So I think the role is vital and very important for those practical issues.'

Some informants provided more nuanced assessments of DRT's support for recovery. One informant (a CPN) stated:

> 'When it works, it works very well. I've been working with them since they were created, so I've got a variety of experiences over the years. When people engage, they work very well, although in the last year I've felt a little let down. I felt they weren't, maybe, as flexible as I'd hoped they could be with referral things. But the individual case work that they do, once they engage them, it's normally to a very high standard. Occasionally, questions are raised about just how hard they try to engage someone. It can be a wee bit variable, I think, depending on the team.'

Another respondent stated that success was variable amongst the 3 to 4 clients she had referred. She highlighted the long term nature of recovery and stated that different approaches differently depending on the stage at which a client was at. A CPN respondent stated that while DRT is good at signposting and supporting individuals, success in recovery depended on the client's motivation.

Almost all informants felt that the 16-week time-frame of work was sometimes a constraint on achieving recovery and the DRT should be less rigid in this. However one informant's experience suggested that service users might become too dependent on the DRT worker due to the intensive nature of the work. Hence, he felt that the time frame was adequate for most clients.

Complex needs

Respondents were asked to comment on DRT's effectiveness in supporting individuals with complex needs. All respondents felt that DRT did well on this count. Some referrers from health backgrounds felt that DRT workers could become over-involved and didn't allow clients to do things for themselves.

Referrers highlighted the knowledge and networks of DRT staff. One informant (JP) felt that DRT staff was very knowledgeable and aware of the complexity of issues around drug use and mental health. This gave her a great deal of reassurance in being able to refer her clients. She particularly felt that DRT was able to address the day to day chaos and complexity of drug users' lives and capable of maintaining necessary boundaries.

Another informant from a mental health nursing background stated:

> '..I think DRT are very, very good at linking in with services in allowing the person's mental health to be looked at. Not just as a, 'Well, it must be the drugs that are making their mental health the way it is.' They can access your services. I think they all have experience in dealing with people with mental health issues as well, which makes a difference, say, in anxiety, depression. They, again, will go into people's houses, and they will help people with their self-esteem, with their anxiety issues, and they know that is stuff they can take time to do on an individualised basis.'

Respondents felt that improvements in addressing complex needs related to resource. One informant stated that there should be more such services. Several suggested that more flexibility with the 16-week time frame would provide an enhanced ability to address complex needs.

Service users

Respondents were asked about the type of people they refer to DRT and why as well as those who they wouldn't refer. Responses were largely similar across the board. Referrers spoke about referring people who wanted to engage, who lack social support, who were socially isolated and who had complex needs. A striking point was that informants mainly referred people who were 'ready to move on' or 'stable' suggesting that referrers carefully considered the client's suitability for the service. Most referrers would not refer someone who had employment or stable housing.

Child protection

Referrers were asked to comment on DRT's work with children and families. Referrers were highly appreciative of DRT's expertise in this area. One addictions worker stated that DRT was very good with child protection issues and 'always in regular contact and discussion'. Specific expertise in this area was seen as important as it provided specialist knowledge and support to others in health care settings for whom child protection is not a core activity. Most referrers felt this was an important role for DRT. However, one referrer felt that DRT didn't advertise this aspect of their work sufficiently and that more efforts should be made to make referrers aware of this. Another referrer suggested that the short time frame of DRT intervention might make work around child protection difficult. A small number of referrers stated they did not deal with clients who had children or child care/protection issues. (This was also stated in the ART evaluation.)

One referrer explored the complexity of working with service users when their needs conflict with those of their children. She was acutely aware that the DRT worker might be first 'on the scene', and then might have to 'do something about it':

> '… Because someone's on methadone, that doesn't make them a bad parent. If someone's injecting £50 of heroin a day, then they probably are not very good parents at that moment in time. Do you remove the child, do you remove the parent, is there enough foster carers, what do you do? It is very, very difficult, and I think DRT […] they have to do something about it. So as well as the, kind of, up-side of them being able to report back when things in the house are good and things are going really well, and the childcare's good they're, also, possibly, first on the scene when it's not so good, and then they have to do something about that […] it's a whole minefield, but I think, as a society, I don't think we do enough. I think, as a profession, we do the best we can, but sometimes I'm not convinced it's enough.'

This point was picked up in the case-file analysis. Here the DRT social worker recorded that a service user was reluctant to engage because of a conflict of interests and what they perceived as the threat of having their children taken into care.

<u>The nature of DRT service delivery</u>

Respondents were asked to describe and evaluate DRT's approach to service delivery. All informants were well aware of DRT's role. It was dominantly viewed as a holistic, individualised service that responded to a range of client needs. A number of strengths were elicited. The service was seen as dependable and approachable. Workers were credited with having an excellent knowledge of resources, as one CPN referrer stated: 'They have fingers in all pies in Edinburgh'. The assertive nature of DRT work was seen as beneficial to clients. Flexibility and adaptability to respond to multiple client needs in a holistic manner was seen as the service's 'comparative advantage' over other drug agencies in the city.

Informants felt that the biggest weakness of DRT was inflexibility over the 16 week time limit. Though, some referrers felt that longer working times could lead to dependence. There was a general view that for this client group the time frame of working needed to be individualized to suit each person's needs.

7.2.4 Service users' views

As with the ART data, narratives of service users illustrate the complex nature of their lives, and arising from this, the difficulty of claiming that one particular service or intervention has been effective in its own right. All the service users worked with multiple agencies at the

same time; indeed one of the goals of DRT is to refer clients on to other resources. Thus it was difficult to determine the extent to which one agency or approach contributed to 'success'. These difficulties in evaluating success are amplified by the chaotic nature of the lives of some service users.

Nature of DRT service delivery

Service users were all invited to comment on three specific areas in relation to DRT's effectiveness: the style of delivery, the 16 week contract with service users, and the relationships they had with the social workers.

A majority of service users welcomed the flexibility of the team to do home visits or meet outside the office. P expressed a positive view:

> 'It's like meeting you in your, sort of, domain, in your environment. You don't need any airs or graces, and you don't feel as if...you're obviously delighted and that and the house is usually a wee bit tidier than this. I feel it's refreshing especially a young lassie coming to a young man's door. I could have been anybody. So, it's...I raise my glass to them, like, meeting you on your own doorstep.'

Another service user stated: 'I feel comfortable just in my own place, especially talking something deep, I just, you know?' (L) However, it was also clear that some clients preferred to meet outside of their home and DRT appeared to accommodate these wishes.

Service users had mixed views about the 16-week timeframe. Most felt this was too short. Others were ambivalent. One client (O) felt that a lot was done in 16 weeks, more than with other agencies but this could still be longer. Another felt it was just right:

> 'It was long enough because I had the support that I was receiving. I actually felt it was fine because I was receiving support and stuff but maybe if I wasn't receiving any of that then maybe [the worker] would have been there longer.' (K)

Another service user felt it was too short but was aware that a longer period could lead to dependence:

> 'Six months, yes. I know there is a kind of danger if it's too long, maybe I'm really co depending to the social worker and it's difficult to stand up on my own feet. However, sixteen weeks, I think it's a bit too short.' (L)

All service users except one expressed satisfaction with the relationships they had with their worker. Social Workers were praised for being dependable, knowledgeable and accessible. Many such as K appreciated the non-directive nature of their approach. It was clear that

bonds had been established with individual workers. This centred on trust and dependability as expressed by L:

> 'Like I said to you, if I had a problem next year or even two years or three years down the line and I thought [workers name] could help me with it, I wouldn't hesitate to call her and I would still have her phone number. I would 100 per cent, hand on my heart, think she would help me with it as well. There's not a problem. So I feel even though I don't deal with her anymore, I know I've got her there in place, if you know what I mean?'

It was evident that service users felt that social workers challenged them on issues and they viewed this as helpful to their recovery.

Work with other agencies

Service users appreciated the ability of DRT Social Workers to coordinate with other agencies and achieve positive outcomes in terms of quick referrals or processing of applications. This was seen as an important contribution to their lives, as P stated: 'It's, like, they open up a load of doors for you that you didn't know were there.'

7.2.5 Conclusion

It is very difficult to measure effectiveness of this type of service and in relation to this client group. We have reviewed two sources of data: randomly-selected service user evaluations and qualitative interviews with staff, referrers and service users. A number of conclusions emerge. Service user evaluations highlight the range of help people receive. Clients self-assess as better off after intervention and state that they value relationships with the team, and in particular, with their social worker. Views of staff are in line with the defined ethos of DRT as a person-centred service. However, the interviews also highlight the challenging landscape in which DRT operates. Referrers and service users saw the service in positive terms and all three sets of interviews highlight that DRT's effectiveness is linked to positive relationships that social workers develop with clients. Only a small number of service users from within our sample had contact with children. Those who did felt that their relationship with Children and Families' social work had improved, as had contact with their children, suggesting an important advocacy role for DRT here.

8 Final conclusions and recommendations

8.1 ART Findings

ART's stated outcome measures include: reduction in alcohol consumption; improvements in employment and accommodation status; improvements in financial situation; improvements in contact with non-alcohol users; and more and better use of a range of services.

Outputs

The findings suggest that ART service users are, on the whole, an older client group, predominantly white with a range of complex needs. Child protection does not feature highly, reflecting the age of service users. The evidence suggests that the agency addresses a range of issues and provides support in terms of referral, advocacy, emotional and social support and information and advice. Service users said they had been helped, in sometimes small, but realistic ways, and that help with welfare rights or housing in the first instance may be a necessary prerequisite for recovery later on. It is suggested that ART could do more to engage with young women and to address the needs of the BME community.

Effectiveness

The findings indicate overall that ART is providing a professional, expert and useful service to a range of troubled and troubling clients. There is consistent evidence of alcohol reduction amongst service users and improved feelings of well-being. The chaos of daily living is improved through access to ART services, but it is difficult to quantify this, not least because all service users are also in touch with other services (often as a direct result of ART involvement). Service users acknowledged that ART social workers had played a key part in their recovery journey. This was largely down to the relationship that they were able to build with their social workers. It was also reflective of the professional identity of social workers, an identity that gave them expert knowledge and allowed them to leverage resources to assist clients to achieve their objectives. There was, however, concern stated by all those who took part in the evaluation that the rigidity of the 16-week programme may have impeded progress for some service users. The importance of good communication was stressed, between staff and service users but also between agencies and professionals.

8.2 DRT Findings

DRT's stated outcome measures include: reduced use of (illicit) drugs; improved psychological health, reduced chaos is daily living; increased self-worth; increased access to a wide range or treatment and other therapeutic interventions and children are safer.

Outputs

Findings suggest that service users are mainly under the age of 40 years; this is quite a different profile to the ART service users. A small number of service users had responsibility for the care of children, who either live with them or who are 'looked after' elsewhere. In common with ART, there were very few BME service users. A high percentage of service users had physical and mental health problems. A majority of referrals come from health sources. The evidence suggests (again as with ART) that the agency does address a range of issues and provides support in referral, advocacy, emotional and social support and information and advice. A high number of needs were addressed by those who completed the programme, focusing on housing, finance and social support, including education. The lack of services to which DRT social workers could refer those with mental health problems was highlighted in the evaluation.

Effectiveness

A number of conclusions emerge. Service user evaluations highlight the range of help people receive. Clients reported being better off after intervention: about half reported a decrease in their prescriptions, whilst a smaller number said they were using illicit drugs less often (some said they were no longer using illicit drugs). Most service users stated that their physical and mental health had improved, probably because other aspects of their lives were improved (such as housing, finance and social support). However, the interviews also highlight the challenging landscape in which DRT operates. Referrers and service users saw the service in positive terms and all three sets of interviews assert that DRT's effectiveness is linked to positive relationships that social workers are able to develop with clients. Referrers were positive about the role of DRT in relation to child protection and appreciated their specialist knowledge and skills in this area. Those service users from within our sample who had contact with children felt that their relationship with their children and families' social worker had improved, as had contact with their children, suggesting an important advocacy role for DRT.

8.3 Common issues between ART and DRT

There are a number of systemic and organisational components common to both ART and DRT that frame the service delivery, bringing opportunities and challenges for consideration.

Nature of service delivery

Both ART and DRT are, as their name suggests, referral agencies: their task is to carry out a full assessment and then refer people on to other agencies and services. They are not, in this sense, therapeutic agencies, but they are, nevertheless, 'social work' agencies: intervention is carried out by qualified social workers who have all undergone further professional training in substance use. We were asked to consider: what is the 'added value' of a social work response like this to supporting people with alcohol and drug problems? It has proved impossible to answer this question categorically, not least because we did not set out to compare and contrast outcomes with those who did not receive a social work service. The closest answer we can give, however, picks up a number of points made by referrers and service users, that is, that ART and DRT provide a holistic service: a service which sees individuals within the full context of their individual histories, lives, families and communities, and seeks to walk alongside service users as they make changes towards recovery. It is this willingness to see beyond the identified problem and to build relationships that is the hallmark of a social work service, as Galvani (2012:1) asserts:

> 'Social work is a helping profession. While the organisational and policy context in which is sits changes and evolves, at its core remains a profession that seeks to help other people in need of support or at risk of harm. Among these people are those whose use of alcohol or drugs causes, or contributes to, problems to themselves or others.'

Being a social work service run by the Council also brings 'added value' in terms of knowledge of, and access to, other services. Both referrers and service users said they appreciated that as social workers employed by the Council, ART and DRT staff had easy access to other council-run services, including, of course, social work services. They also had expert, 'insider' knowledge of social work and social work processes and referrers and service users were able to take advantage of this. This was particularly identified in the context of child protection, a field of practice with which other addictions' agencies clearly feel less comfortable.

Beyond this, ART and DRT provide a unique service, one which focuses on the needs and strengths of service users. The assessment and care plan that is developed follows the

aspirations and goals of service users, not simply agency targets. A flexible approach means that service users can be visited at home, met in a café or accompanied on visits. Service users and referrers commented on this most positively, as well as on the emphasis on social activities and building structure in daily life. There were, however, quite divergent opinions about the services' 16-week programme, with some views expressed that this could never be enough to do anything other than start someone on a recovery journey. (While service users can and are re-referred at the end of 16 weeks, we heard that this may lead to a delay because the person is placed on the waiting list again.) Some informants felt that brief intervention like this is helpful, because it reduces the likelihood of dependency. Interestingly, in both ART and DRT, the focus of intervention is likely to be on an issue such as housing, finance or social aspects, rather than on either alcohol or drug issues directly. This is because in all instances, a health professional was also working with the client. There is some evidence from the evaluation that the amount of agencies and personnel involved in a service user's life can be confusing and there is an important role for ART and DRT in facilitating access between different professionals. The new 'recovery hubs' promise much for future inter-agency working, although significant differences of epistemology and approach in relation to drug and alcohol misuse are likely to remain (especially focused on the question of abstinence).

Nature of the service deliverers

The success or failure of a service like ART and DRT is largely down to the professionalism and experience of its staff. Because ART and DRT are referral agencies, they have nothing to offer but themselves; the relationship between the service user and social worker is at the heart of the case management approach adopted. The social worker acts as a catalyst to change, as long as the service user is ready and willing to commit to change. The social worker must also be able to address complex needs. At times, this means coping with difficult and challenging behaviour, and being able to 'hold' a person through their distress, even though this is not intended to be a therapeutic relationship. Achieving this balance requires good training and support, both of which have been identified by ART and DRT staff and referrers.

Nature of the systems and structures within which the agencies operate

A number of different sets of outcomes and targets have been identified by this evaluation, and ART and DRT have to demonstrate performance across all of them. There are, moreover, a number of different systems in place for recording, leading to inevitable

repetition in some places, and gaps in others, and also great difficulty in identifying just what has happened with each service user. This has implications not only for agency monitoring processes, but also for work with service users, and for contact with other agencies, many of whom said they would like to hear how the client they had referred had fared.

There have been a number of suggestions in this evaluation that ART and DRT might come together in the future. Whilst this was not a topic that we set out to investigate, it should be stated that there are clearly pros and cons to this development as identified in the evaluation. Whatever happens, it is important that both services maintain close links in the future.

8.4 Recommendations

- That ART and DRT continue to provide services to these client-groups.
- That DRT continues to provide specialist child protection services to what is an exceptionally difficult service-user group with which to engage.
- That ART and DRT reconsider the 16-week service time-limit to see whether a more flexible approach might yield improved outcomes for service users.
- That ART and DRT revisit their record-keeping systems in order to simplify systems and provide useful evaluative information.
- That ART and DRT standardise their systems across the agencies so that it is easier to draw comparisons between service user groups.
- That ART and DRT explore what needs to be done to make the services more accessible to black and minority ethnic people in the future.
- That ART and DRT improve their feedback of service users' progress to referrers.
- That ART and DRT explore ways of involving service users more in service development.

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10 Appendix: Interview Schedule

A similar set of questions was addressed to all three stakeholder groups (staff, referrers and service users) in order to ensure consistency.

1 ART/DRT ETHOS

1.1. How would you define ART/DRT's ethos?

1.2. How is this operationalised in practice?

1.3. What knowledge base/theoretical approach underpins the ART/DRT service?

2 RECOVERY: FROM POLICY TO PRACTICE

2.1 Government policy promotes a recovery-orientated approach to tackling alcohol/drug problems. What does 'recovery' mean to you? In other words, in your opinion, 'what works' in supporting people in their recovery journey?

2.2 What does recovery mean to the ART/DRT? How does the ART/DRT seek to put a recovery-orientated approach into practice?

2.3 Does it work? Do you see evidence of service users progressing in their recovery in 'real terms'?

3 COMPLEX NEEDS: FROM POLICY TO PRACTICE

3.1 How does ART/DRT address complex needs as defined by government policy?

3.2 In your opinion, how effective is ART/DRT approach to complex needs?

3.3 Could more be done? Could things be done differently to address issues of complex needs?

4 ART/DRT SERVICES

4.1. What are the strengths of the ART/DRT approach to service delivery?

4.2 What makes this a 'social work' service?

4.3 How far would you say this is a personalised or person-centred service?

4.4 What are the weaknesses of the ART/DRT approach/areas that might be improved?

4.5 Is there anything you would like to do differently?

4.6 Are there any negative or unintended consequences of receiving as service from ART/DRT? If so, what are they?

5 SERVICE USERS - INDIVIDUAL DIFFERENCES

5.2 What does recovery look like for different service users?

5.3 Are some service users more difficult to help than others, of so, who are they?

5.2 How do the differences between specific needs and problems impact on individuals' recovery?

5.3 Are some kinds of individual goals or objectives easier to achieve than others? Is so, what are they?

5.4 Why do you think this is so?

5.5 What does the idea of relationship mean to you in your work with service users?

6 CHILD CARE AND PROTECTION

6.1 Is child care and protection an issue for ART/DRT?

6.2 If so, how does ART/DRT deal with issues of child protection?

6.3 How effective is ART/DRT's approach?

6.4 Could more be done by ART/DRT or could things be done differently by ART/DRT to protect children at risk of harm?

6.5 What are the obstacles to achieving this?

7 SUPPORT AND TRAINING FOR STAFF

7.1 What kind of professional training did you have before coming to ART/DRT?

7.2 What training have you had since coming to ART/DRT?

7.3 Do you see any gaps in your training needs?

7.4 What kind of support do you have to do your job?

7.5 Any comments on this?

8 RELATIONSHIPS WITH OTHER AGENCIES

8.1 What are the other agencies which ART/DRT works with most often?

8.2 How does ART/DRT engage with other agencies (alcohol/drug services and other agencies)?

8.3 Would you want to see this handled differently?

8.4 If so, how might it be improved?

8.5 What are the obstacles to achieving this?

9 SERVICE USER INVOLVEMENT

9.1 Are service users involved in the design, development and delivery of the service?

9.2 If yes, how?

9.3 Would you want to see this developed?

9.4 If so, how?

9.5 What are the obstacles to achieving this?

10 FINAL THOUGHTS

10.1 What are the unique features of ART/DRT's approach? What it its USP??

10.2 Is there anything you would like to be done differently at ART/DRT (ethos, approach, resources, training)?